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Medical Malpractice in Perspective: Nebraska Hospital-Medical Liability Act

I. INTRODUCTION

In the early through mid-1970's, the health care industry in many states faced a serious medical malpractice crisis.¹ It was characterized by an enormous increase in the number of malpractice claims;² a significant increase in the amount of damages awarded to prevailing patients;³ a serious decline in the availability of malpractice insurance;⁴ a dramatic rise in premiums demanded by those companies which continued to issue policies;⁵ an alarming

1. See U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, MEDICAL MALPRACTICE REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, 1-4 (HEW Pub. No. (OS) 73-88, 1973) [hereinafter cited as MALPRACTICE REPORT]. See also ABA COMMISSION ON MEDICAL PROFESSIONAL LIABILITY, 1977 REPORT [hereinafter cited as ABA REPORT]; Blaut, *The Medical Crisis—Its Causes and Future*, 44 INS. COUNSEL J. 114 (1977); Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759 (1977); Comment, *Recent Medical Malpractice Legislation—A First Checkup*, 50 TUL. L. REV. 655 (1976).
 2. See MALPRACTICE REPORT, *supra* note 1, at 5-8; Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489, 490-91 (1977). See also T. LOMBARDI, MEDICAL MALPRACTICE INSURANCE 1-81 (1978).
 3. See Witherspoon, *Constitutionality of the Texas Statute Limiting Liability for Medical Malpractice*, 10 TEX. TECH. L. REV. 419, 446 n.123 (1979); *Federal Medical Malpractice Insurance Act: Hearing Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare*, 94th Cong., 1st Sess. 161 (1975).
 4. See Redish, *supra* note 1, at 759-60. See generally Gibbs, *Insurance Crisis: Availability to Physicians In Jeopardy*, J. LEGAL MED., Feb., 1975, at 29; Gray, *The Insurer's Dilemma*, 51 IND. L.J. 120 (1975); Roddis & Stewart, *The Insurance of Medical Losses*, 1975 DUKE L.J. 1281.
 5. The increase in medical malpractice insurance rates for physicians, brought about by increases in both the number of claims and the average value of those claims, has been as much as fivefold from 1965 through 1974. By mid-1975 rate levels for physicians and surgeons professional liability insurance in some states were more than 100 per cent higher than 1974 levels.
- Witherspoon, *supra* note 3, at 427-28 n.43. See also Redish, *supra* note 1, at 759-60; Segar, *Is Malpractice Insurable?*, 51 IND. L.J. 128 (1975).

trend toward defensive medical practices⁶ and away from high-risk specialization;⁷ and a continual rise in costs to patients.⁸ These problems were pervasive: "[T]he problem touches every facet of our health-care delivery system. Costs, patterns of medical practice and forms of medical treatment, the distribution of health manpower, the relationships between doctors and patients, even confidence in equal justice before the law—all of these and more are affected by the problem."⁹

Nebraska, like many other states, responded to the crisis with legislation. The Nebraska Hospital-Medical Liability Act,¹⁰ enacted in 1976, significantly alters the substantive and procedural rules relating to medical malpractice actions. This comment will examine both the malpractice crisis and Nebraska's legislative response. First, the history of the malpractice crisis and its causes will be evaluated in an effort to discern whether Nebraska's broad legislation was truly necessary. Then, the Nebraska Act will be analyzed in some detail, with comparisons to similar statutes from other states, and discussions of the Nebraska Supreme Court decision upholding the Act, *Prendergast v. Nelson*.¹¹ Alternatives to the Nebraska approach will be considered throughout.

II. HISTORICAL PERSPECTIVE

Suits for medical malpractice¹² were rare¹³ before 1930.¹⁴ Indi-

6. See notes 111-16 & accompanying text *infra*.

7. See note 109 & accompanying text *infra*.

8. See text accompanying note 114 *infra*.

9. MALPRACTICE REPORT, *supra* note 1, at 2.

10. NEB. REV. STAT. §§ 44-2801 to -2855 (Reissue 1978).

11. 199 Neb. 97, 256 N.W.2d 657 (1977). Numerous constitutional challenges to medical malpractice legislation have been equally unsuccessful. See, e.g., *Eastin v. Broomfield*, 116 Ariz. 576, 570 P.2d 744 (1977); *State ex rel. Schneider v. Liggett*, 223 Kan. 610, 576 P.2d 221 (1978); *Everett v. Goldman*, 359 So. 2d 1256 (La. 1978); *Attorney General v. Johnson*, 282 Md. 274, 385 A.2d 57 (Ct. App.), *appeal dismissed*, 439 U.S. 805 (1978); *Paro v. Longwood Hosp.*, 369 N.E.2d 985 (Mass. 1977). But see *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978).

12. Malpractice has been defined as "a dereliction from professional duty whether intentional, criminal, or merely negligent by one rendering professional services that results in injury, loss, or damage to the recipient of those services or to those entitled to rely upon them . . ." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1368 (unabr. ed. 1971). See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 32, at 161-66 (4th ed. 1971); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959). See also BLACK'S LAW DICTIONARY 1111 (rev. 4th ed. 1968) (malpractice: "Any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct.").

13. It may still be true that suits or claims for malpractice are relatively rare in comparison to the number of incidents of malpractice. A 1978 Rand Corpora-

viduals accepted sickness and death as inevitable, and dissatisfied patients rarely looked to the courts for satisfaction: "[M]edicine itself was comparatively limited and adverse results of treatment more often than not were either regarded as the natural outcome of disease or attributed to 'the will of God.'"¹⁵

In the 1930's noticeable increases in the number of malpractice suits occurred in several states, but these suits declined in the period just prior to World War II.¹⁶ However, in the post-World War II era, the number of malpractice suits steadily increased,¹⁷ an upward spiral that culminated in the malpractice crisis we experienced in the early seventies. The following section explores the most commonly suggested reasons for this dramatic increase.

A. The Causes

Unfortunately, there are no definitive explanations for the dramatic increase¹⁸ in malpractice claims and actions although numerous theories have been offered. Then too, the seriousness of the crisis often depended on an individual's perspective.¹⁹ Contrasting theories, statistics and studies abounded at the height of the crisis which only fueled the flames of accusation. The malpractice situation was

a vicious circle [in which] physicians, attorneys and insurance companies blame[d] one another for creating and aggravating the problem. Physicians criticize[d] attorneys for abusing the contingent fee system; both groups berate[d] insurers for having impersonal philosophies. The medical profession itself was attacked by attorneys, insurers and patients for its diminishing physician-patient rapport and for permitting malpractice misadventures.²⁰

Although there was little hard quantitative evidence,²¹ all par-

tion Study concluded that only one out of every ten apparent incidents of malpractice ever result in a claim. MALPRACTICE DIG., Jan./Feb. 1979, at 4. See also MALPRACTICE REPORT, *supra* note 1, at 2-3, 12; Stewart, *The Malpractice Problem—Its Cause and Cure: The Physician's Perspective*, 51 IND. L.J. 134, 134 (1975); notes 360-64 & accompanying text *infra*.

14. MALPRACTICE REPORT, *supra* note 1, at 3.

15. *Id.*

16. *Id.*

17. *Id.*

18. "[T]here is no uniquely identifiable 'malpractice problem,' but rather, a complex of problems involving interacting medical, legal, sociological, psychological, and economic factors." MALPRACTICE REPORT, *supra* note 1, at 4.

19. Some commentators believe that there was no true malpractice crisis. See, e.g., Witherspoon, *supra* note 3.

20. 9 IND. L. REV. 594, 595 (1976).

21. See MALPRACTICE REPORT, *supra* note 1, at 21. See also MALPRACTICE IN FOCUS, AN AMA SOURCE DOCUMENT 11 (1975) [hereinafter cited as MALPRACTICE IN FOCUS] ("Millions of words already have been addressed to the malpractice crisis, sometimes numbing the brain and obscuring core issues. Unfortu-

ties continued to point their fingers and attribute the blame to anyone, and everyone, but themselves. Certainly the rhetoric and speculation impeded the search for a viable solution.

When analyzing the malpractice issue in perspective it is apparent that a myriad of medical, legal, social and economic factors created the problem. No single villain caused the crisis and no simple panacea will solve it.²²

1. *Legal Causes*

a. *Contingent Fees*²³

A lively controversy surrounds this system of attorney compensation.²⁴ Health care providers accuse greedy attorneys of instigating vexatious litigation. They believe that "contingent fees prompt lawyers to pursue claims of dubious merit in the hope of securing a large verdict from a sympathetic jury, and to seek irresponsibly high recoveries for legitimate claims."²⁵ These arguments have merit because a health care provider may not contest a small claim since malpractice litigation involves extensive costs.²⁶ Moreover, health care providers may frequently settle what they perceive to be nuisance suits primarily to avoid needless vexation. This practice only encourages additional unnecessary litigation according to the critics of the contingent fee system.²⁷

However, the evidence indicates that the contingent fee system does not overcompensate plaintiffs' attorneys for their legal services. One extensive study found that plaintiffs' attorneys are compensated fairly for their services (an average of \$63 an hour in 1973) and that defense attorneys earned roughly the same amount (\$50 an hour).²⁸ Furthermore, attorneys reject the majority of po-

nately, reliable up-to-date information on the full extent of the problem has been sadly lacking."); Abraham, *supra* note 2, at 532.

22. ABA REPORT, *supra* note 1, at 15; Comment, *supra* note 1, at 655-59.

23. A contingent fee is that amount which the attorney and client stipulate will be paid to an attorney for his services only if he wins. Generally this is a percentage of the amount recovered. BLACK'S LAW DICTIONARY 740-41 (rev. 4th ed. 1968). See generally F. MACKINNON, CONTINGENT FEES FOR LEGAL SERVICES (1964).

24. See, e.g., MALPRACTICE REPORT, *supra* note 1, at 32-33; Schwartz & Mitchell, *An Economic Analysis of the Contingent Fee in Personal-Injury Litigation*, 22 STAN. L. REV. 1125 (1970); Stewart, *supra* note 13, at 138-39; Comment, *supra* note 1, at 670.

25. Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417, 1443.

26. See Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179, 1182-83.

27. *Id.* at 1183. But see note 110 *infra* (health care providers have fought this trend with various types of counter-suits).

28. MALPRACTICE REPORT, *supra* note 1, at 32-33.

tential medical malpractice claims because these actions involve many inherent risks.²⁹ The contingent fee system discourages most attorneys from accepting meritless and small claims since they may invest a significant amount of time but receive little or no recovery.³⁰ Proponents also claim that without it, individuals with meritorious claims but insufficient resources would be unable to pursue meaningfully any remedy, since few qualified attorneys would be willing to work for a client who was unable to pay for their services.³¹ The contingent fee system allows the client to pursue a claim but avoid the often crippling burden of legal expenses,³² a particularly relevant factor in light of the inordinate length of the typical malpractice trial.³³ Nevertheless, health care providers have persuaded the state legislatures to adopt various methods of regulating legal fees.³⁴

b. *Res Ipsa Loquitur*

Critics point to the doctrine of *res ipsa loquitur* as a prime example of procedural discretion which places the health care provider or hospital at a distinct disadvantage.³⁵ Interpreted as "the thing speaks for itself", *res ipsa loquitur* is an evidentiary rule that creates a rebuttable presumption that the defendant was negligent. There are three conditions which are usually necessary for the application of the principle: (1) an injury occurs which is of the type that ordinarily does not occur except for someone's negligence, (2) the agency or instrument which caused the injury must have been within the exclusive control of the defendant, and (3)

29. One national survey revealed that the plaintiffs' attorneys accept only 12% of the claims reviewed. MALPRACTICE DIG., Sept./Oct. 1978, at 2. As one commentator noted:

The fact is that a malpractice case is by far the riskiest type of legal action undertaken today . . . The risk in time and money of beginning a frivolous malpractice action is simply too great. Attorneys who specialize in medical malpractice turn away the substantial majority of potential clients who walk into their office alleging injury at the hands of a physician.

MALPRACTICE LIFELINE, Aug. 28, 1978, at 3 (quoting Alan Y. Medvin).

30. See MALPRACTICE REPORT, *supra* note 1, at 33. Half of the attorneys who win a malpractice suit on a one-third contingent fee basis earn less than \$1,000. *Id.* at 34.

31. Comment, *supra* note 25, at 1442.

32. See MALPRACTICE REPORT, *supra* note 1, at 35; Abraham, *supra* note 2, at 491; Mallor, *A Cure for Plaintiffs' Ills?*, 51 IND. L.J. 103, 105-06 (1975).

33. Most malpractice suits take from four to five years to resolve. MALPRACTICE REPORT, *supra* note 1, at 89.

34. See notes 219-31 & accompanying text *infra*.

35. See MALPRACTICE REPORT, *supra* note 1, at 28-29; Comment, *supra* note 25, at 1426-29.

the plaintiff must be free of any contributory negligence.³⁶

The medical profession anticipates that this doctrine may be invoked in all malpractice cases in order to force health care providers to carry the burden of proof and demonstrate that they were not negligent.³⁷ However, this doctrine applies infrequently in medical malpractice actions, and is not allowed to substitute for proof where the allegations involve specific acts of negligence.³⁸ For instance, *res ipsa loquitur* applies when foreign objects are left in the patient's body after surgery³⁹ or when the patient suffers unexplained injuries during the course of surgery.⁴⁰ The application of the doctrine to these limited situations⁴¹ is justified on the theory that the defendants are in a much better position than the patient to explain the injury.⁴²

c. Jury Verdicts

Health care providers charge that juries are frequently influ-

36. W. PROSSER, *supra* note 12, § 39, at 214. See *Ybarra v. Spangard*, 25 Cal. 2d 486, 489-90, 154 P.2d 687, 689 (1944).

37. Comment, *supra* note 25, at 1426. However, this does not appear to be applicable in Nebraska. See, e.g., *Kortus v. Jensen*, 195 Neb. 261, 237 N.W.2d 845 (1976).

[P]roof of medical negligence (malpractice) requires two basic evidentiary steps, followed by proof relating to proximate cause and damages: (1) Evidence of the generally accepted and recognized standard of care . . . ; and (2) a showing that the physician or surgeon in question negligently departed from that standard in his treatment of the plaintiff. The burden of establishing *both* these essential elements rests upon the plaintiff's introduction of expert medical testimony. The doctrine of *res ipsa loquitur* is inapplicable here.

Id. at 268, 237 N.W.2d at 850 (emphasis in original).

38. MALPRACTICE REPORT, *supra* note 1, at 28.

39. *Id.* See W. PROSSER, *supra* note 12, § 39, at 227-28.

40. For a collection of cases addressing this issue, see W. PROSSER, *supra* note 12, § 39, at 227-28 nn.4-9. The leading case applying the *res ipsa* doctrine is *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944), a case in which the court held the application of *res ipsa* was proper where the patient received unusual injuries while unconscious and in the course of medical treatment by numerous health care providers.

41. It appears, however, that application of the doctrine may be expanding. The HEW Commission found that in the period prior to 1950, *res ipsa* was considered in only 6.3% of the cases, but in the period from 1961-1971 it was considered in 13.4% of the cases. MALPRACTICE REPORT, *supra* note 1, at 29. Additionally, *res ipsa* has been expanded in California to include "rare-accident" cases. *Id.* at 28. See, e.g., *Clark v. Gibbons*, 66 Cal. 2d 399, 426 P.2d 525 (1967); *Quintal v. Laurel Grove Hosp.*, 62 Cal. 2d 154, 397 P.2d 161 (1964). In response to this trend some states have enacted statutes which require proof by the plaintiff of the health care provider's negligence, which in essence, negates the *res ipsa* doctrine. See, e.g., TENN. CODE ANN. § 23-3414 (Cum. Supp. 1979); WASH. REV. CODE § 4.24.290 (Supp. 1978).

42. *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944).

enced by clever attorneys who capitalize on the complex and frequently gruesome nature of a malpractice case. Moreover, juries may express sympathy towards the patient and prejudice towards the health care provider⁴³ based on their own experiences with, or perceptions of, the medical profession.⁴⁴ The medical profession accuses juries of increasing the cost of malpractice insurance because when juries are used, they are time consuming and their verdicts are unpredictable.⁴⁵ And, although these charges are not unique to the jury system, "they are especially pertinent in the medical malpractice area because of the increasing number of claims, the sensitivity and technical complexity of that area, and the large dollar amounts at stake."⁴⁶

Although the data is inconclusive,⁴⁷ malpractice litigation in all likelihood confuses many jurors since it involves complex terminology, concepts and expert testimony.⁴⁸ To address this problem some commentators have suggested adjustments in the roles of judges and juries in medical malpractice litigation.⁴⁹ The legislatures have responded with various alternatives, such as requiring preliminary review by a medical review panel,⁵⁰ or substituting arbitration panels⁵¹ for the jury in malpractice cases. These meas-

43. Segar, *supra* note 5, at 140.

44. Anger, revenge, hostility and resentment towards health care providers are frequently suggested as the key ingredients leading to malpractice actions. The impersonality of the doctor/patient relationship frustrates and angers the patient. Many health care providers are perceived as "arrogant, egotistical, condescending, [and] aloof." MALPRACTICE LIFELINE, July 24, 1978, at 5. Moreover, many individuals may share these feelings even if they have had no misfortunes personally, so potential bias against the medical profession may exist at the outset of the proceedings. For an excellent analysis of why many health care providers attract the public's wrath, see R. GOTS, THE TRUTH ABOUT MEDICAL MALPRACTICE 14-19 (1975). But see Peterson, *Consumers' Knowledge of and Attitudes Toward Medical Malpractice*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 658 (Appendix).

45. Comment, *supra* note 25, at 1455. Additional factors that impede settlements are "the defendant/physician's right to refuse settlement, a tendency of malpractice insurers to wait until the last minute before trial to settle, a lack of lawyer preparation, the long wait to trial, plaintiffs' demand for jury trial, unreasonably high award demands, and ineffective pretrial procedures." *Id.* at 1455 n.188.

46. *Id.* at 1455.

47. MALPRACTICE REPORT, *supra* note 1, at 18.

48. *Id.*

49. Abraham, *supra* note 2, at 508-12.

50. *Id.* at 512. See notes 267-352 & accompanying text *infra*.

51. An arbitration panel can be distinguished from a screening panel in that the former vests full decision-making power in the hands of non-judicial arbitrators selected by the parties. Arbitration resolves all claims at this stage, thus avoiding any need for a trial. Screening panels, however, are intended only to encourage settlement of meritless claims, without eliminating the parties' rights to proceed to trial. See Redish, *supra* note 1, at 768-69, 796-800; Com-

ures are intended to minimize the number of cases which ultimately must be tried by a jury by resolving disputes at the earliest possible stages.

d. Meritless Litigation

Most health care providers are convinced that they are unjustly harassed by the legal profession.⁵² Lawyers are seen as profiteers,⁵³ who needlessly persecute health care providers, often second-guessing their action and initiating unnecessary malpractice actions.⁵⁴ In one national survey, for instance, physicians stated that aggressive attorneys caused the malpractice situation to deteriorate significantly.⁵⁵

It appears, however, that most lawyers not only do not actively pursue malpractice work but persistently avoid it.⁵⁶ The primary reasons for this are that traditional malpractice suits⁵⁷ are excep-

ment, *supra* note 25, at 1463-67. The advantages and disadvantages of various methods of arbitration are discussed in MALPRACTICE REPORT, *supra* note 1, at 91-96. See generally MALPRACTICE REPORT, *supra* note 1, at 214-449 (Appendix) (extensive studies on various medical malpractice arbitration panels).

52. Pabst, *A Medical Opinion Survey of Physicians' Attitudes on Medical Malpractice*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 83 (Appendix); Rathnau, *The Illinois Medical Malpractice Acts: Response to Crisis*, 65 ILL. B.J. 716, 720 (1977).

53. 39 OHIO ST. L.J. 855, 859 (1978).

54. California has recently enacted legislation to minimize the potential for meritless litigation. See CAL. CIV. PRO. CODE § 411.30 (West Cum. Supp. 1979). This provision provides that in all cases involving claims of medical malpractice, the plaintiff's attorney must file a certificate of merit which states that the attorney believes, after reviewing the facts and consulting with qualified individuals in the health care industry, that there is a "reasonable and meritorious cause for filing such action." A violation of this provision may constitute unprofessional conduct and represent grounds for disciplining the attorney.

55. Pabst, *supra* note 52, at 84. The physicians indicated their belief that the most significant contributing factors of the crisis are: (1) poor communication between physician and patient; (2) aggressive lawyers; (3) declining public regard for doctors; (4) increasing complexity of medical practice; (5) increasing public education about medicine; (6) just plain "bad medicine"; (7) the current system of patient care; (8) poorly-trained physicians; and (9) miscellaneous reasons. *Id.*

56. See note 29 *supra*. (Only 12% of malpractice claims reviewed are accepted); Dietz, Baird & Berul, *The Medical Malpractice Legal System*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 87, 99-101 (Appendix); *Committee on Health & Welfare: Hearings on L.B. 434*, 84th Neb. Leg., 2d Sess. 100 (Jan. 27, 1976) (remarks of David Lathrup). But see Mechanic, *supra* note 26, at 1184 (lawyers are more willing to accept malpractice work, and firms are specializing in this area); Comment, *supra* note 1, at 658 (large numbers of plaintiffs' attorneys have become proficient at litigating malpractice claims).

57. A traditional malpractice trial involves all the procedural elements and steps of a typical civil action. The major disadvantages to such procedures in the malpractice context are discussed in Documentary Supplement, *Medical-Le-*

tionally complex,⁵⁸ time consuming⁵⁹ and expensive.⁶⁰ Furthermore, since the attorney's fee is often contingent upon winning, the attorney may expend tremendous time and effort on a case for which he receives no compensation.⁶¹

2. Medical Causes

a. Technological Advances

Medical science throughout the last several decades has advanced at an astronomical pace. Pioneering research has developed extremely sophisticated machinery which has enabled the medical profession to save countless lives and substantially reduce unnecessary suffering. Unfortunately, these achievements are not without inevitable risks: "New drugs, new techniques and new machinery bring with them new risks, and no degree of professional competence and training can guarantee a successful outcome in every medical case. Medicine . . . , for all its widely-heralded accomplishments, is still more art than science."⁶² Since the technology today is so exceptionally complex, human error, even when the health care provider is fully competent and exercises all the necessary precautions, carries the potential for serious, or perhaps disastrous, consequences.⁶³ Adverse results, regardless of the degree of care, may be an inevitable consequence of medical treatment. Although the health care provider's conduct may not be negligent, a patient who has come to expect only the best results may seek compensation for unsatisfactory results even though his injury has little merit as a claim for malpractice. This in turn increases the court congestion and expenses in defending meritless suits.

Along with the tremendous growth in medical technology has

gal Screening Panels as an Alternative Approach to Medical Malpractice Claims, 13 WM. & MARY L. REV. 695, 709-10 (1972).

58. MALPRACTICE REPORT, *supra* note 1, at 18 (emphasis added):

Medical malpractice cases are among the most difficult to try. They usually take from *two to three times longer* than other personal injury cases because of the complexity of the requisite expert medical testimony. Thus, although few in total number, they contribute significantly to the congestion and overload of the court system.

59. See note 33 *supra*.

60. Abraham, *supra* note 2, at 491; Mallor, *supra* note 32, at 105.

61. This appears to be a very real possibility. For instance, in the MALPRACTICE REPORT study it was discovered that "the average number of plaintiff-lawyer hours spent in zero-recovery litigated cases is 440 hours per case." MALPRACTICE REPORT, *supra* note 1, at 33.

62. MALPRACTICE REPORT, *supra* note 1, at 1. See also ABA REPORT, *supra* note 1, at 11.

63. Mechanic, *supra* note 26, at 1181.

come increased medical specialization⁶⁴ which undoubtedly has generated more malpractice litigation. For instance, anesthesiologists and health care providers involved in particularly hazardous types of surgery (orthopedic, gynecological and gastrointestinal) are subject to a greater number of malpractice claims due to the higher risks involved in their procedures.⁶⁵ Additionally, the larger number of professional and non-professional personnel involved in the treatment process⁶⁶ increases the potential for a malpractice incident because with more health care providers involved, the potential for communication and follow-up error increases. Also, the direct communication between physician and patient decreases, which hinders the development of any rapport.⁶⁷

b. Heightened Public Expectations

Primarily as a result of these medical advances, the public now expects near faultlessness from the medical profession. Patients often "believe that physicians can cure any disease, save the life and health of any patient, and correct any kind of physical defect."⁶⁸

Much of this illusion can be attributed to the news media, which often emphasizes dramatic accomplishments while neglecting to discuss the inherent risks and limitations involved in many aspects of medical treatment.⁶⁹ The public is often led to believe miracles are possible when in reality acceptable cures are only in the experimental stages.⁷⁰ The broadcast industry likewise portrays the medical profession in a false light, *i.e.*, one which indicates that no problem is unsurmountable.⁷¹ The results of such falsehoods are exaggerated expectations of the medical profes-

64. *Id.*

65. MALPRACTICE REPORT, *supra* note 1, at 8-9; Comment, *supra* note 1, at 657. See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MALPRACTICE CLAIMS, vol. 2, No. 1, at 26-31 (tables 6-9a), 66-109 (tables 13a-d) (1979) [hereinafter cited as NAIC STUDY]. For an excellent statistical breakdown of the numbers and types of medical injuries and the amount of indemnity paid compared to the number of physicians and hospital beds in each state, see *id.* (tables 28a-d).

66. ABA REPORT, *supra* note 1, at 11.

67. Mechanic, *supra* note 26, at 1183-84.

68. MALPRACTICE REPORT, *supra* note 1, at 70.

69. *Id.* at 70. News coverage of medical achievements should be compared with the sensational news coverage sometimes afforded the medical malpractice area. See *id.* at 18-19. See also Byrnes, *Media and Medical Malpractice*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 653 (Appendix).

70. MALPRACTICE REPORT, *supra* note 1, at 70.

71. *Id.*

sion.⁷² The public becomes desensitized to the inevitable risks of medical treatment, and our expectations of the medical profession often exceed that which the profession can deliver. The Department of Health, Education and Welfare Commission on Medical Malpractice recognized this problem, finding that the "expectations of patients concerning the technical capabilities of medicine are often exaggerated and unrealistic. There is a need to educate all patients concerning the hazards, risks, costs and limitations of medicine in order to reduce disappointment, frustration, and dissatisfaction with the outcome of treatment."⁷³ Patients are often bitter when the results of medical care do not measure up to their prior notions, and this dissatisfaction is expressed in the form of malpractice litigation.⁷⁴ Many patients simply are no longer willing to overlook errors in diagnosis or treatment.⁷⁵ They are prepared to question procedures and results and hold the health care provider liable for adverse consequences.⁷⁶

c. Poor Communications Between Health Care Providers and Patients

A significant amount of data⁷⁷ and commentary⁷⁸ illustrates that poor communications between the health care provider and the patient greatly increases the number of malpractice actions.⁷⁹ A malpractice suit may reflect much more than mere dissatisfaction with the quality of service rendered.⁸⁰ It may represent an expression of anger and resentment directed at the health care

72. *Id.*; ABA REPORT, *supra* note 1, at 11.

73. MALPRACTICE REPORT, *supra* note 1, at 70.

74. Mechanic, *supra* note 26, at 1185.

75. R. GOTS, *supra* note 44, at 15.

76. ABA REPORT, *supra* note 1, at 11.

77. *See, e.g.*, note 55 *supra*.

78. *See, e.g.*, MALPRACTICE REPORT, *supra* note 1, at 67, 71; MALPRACTICE DIG., Jan./Feb. 1979, at 2-3. For a general background discussion of how a lack of understanding between the health care provider and patient can result in malpractice litigation, see 1 D. LOISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 5 (1977) [hereinafter cited as LOISELL & WILLIAMS].

79. ABA REPORT, *supra* note 1, at 11, 22.

80. *But see* MALPRACTICE REPORT, *supra* note 1, at 2 (footnote omitted):

To the vast majority of patients, malpractice may seem no problem at all. They receive high quality care and they are satisfied with it. The thought of suing their doctors or hospitals never enters their minds. Most doctors and other health care providers go through their entire professional lives without being sued. Most large hospitals in any given year treat thousands of patients, none of whom sues.

See also MALPRACTICE LIFELINE, Nov. 21, 1977, at 1 (Ohio study concludes that 87% of consumers rate the quality of care they receive from their doctors as excellent or good, and more than 90% have great confidence in their doctors).

provider or hospital involved.⁸¹ Many patients regard health care providers as greedy, condescending and impersonal, factors which indicate deterioration in the relationships between the health care provider and the patient.⁸² One study concluded that physicians who are likely to be sued frequently are those who are unable to admit their own limitations in training or experience; who neglect or dismiss a dissatisfied patient; who are preoccupied with their personal images and unconcerned with their patients' anxieties or anger; and who are totally indifferent towards the personal and psychological needs of their patients.⁸³ Health care providers are largely responsible for this poor image and resulting breakdown in communication because they have learned to rely on their complex technology, but they have at the same time "largely forgotten the art of medicine and dealing with patients."⁸⁴ The relationship between the health care provider and the patients is frequently depersonalized and characterized by inadequate communication. A patient who is unable to communicate with the health care provider will resort to other means to vent his frustrations, and the evidence seems to indicate clearly that this frequently means seeking legal redress:⁸⁵ "If understanding between physician and patient is not commensurate with the necessary diagnostic and therapeutic activities, there is a strong possibility of a failure of treatment, collapse of the relationship, or both. If both occur at about the same time chances for a lawsuit are strong."⁸⁶

81. Anxiety and frustration, however, may be inevitable during a hospital visit, even under the best circumstances. *MALPRACTICE REPORT*, *supra* note 1, at 69-70.

82. *See, e.g.*, *Mechanic*, *supra* note 26, at 1183-84; *Peterson*, *supra* note 44, at 658; *MALPRACTICE LIFELINE*, Dec. 5, 1977, at 3.

83. *MALPRACTICE REPORT*, *supra* note 1, at 68.

84. *R. GOTS*, *supra* note 44, at 15. However, patients likewise must bear a good deal of the responsibility for the breakdown in communications. Certainly many patients maintain unrealistic attitudes towards health care providers and medicine. *MALPRACTICE REPORT*, *supra* note 1, at 68. Moreover, many are "dogmatic" and quick to blame others when results are unsatisfactory. *Id.* Enhanced communications are certainly a two-way street and patients must realize that they also have responsibilities in this regard. *See MALPRACTICE REPORT*, *supra* note 1, at 70 (special programs suggested to educate the public on various aspects of medicine); *ABA REPORT*, *supra* note 1, at 23-24 (check list of patient responsibilities for improved physician-patient relations and health care).

85. *ABA REPORT*, *supra* note 1, at 22; note 44 *supra*.

86. 1 *LOUISELL & WILLIAMS*, *supra* note 78, ¶ 5.02, at 137 (footnote omitted). But a malpractice suit is a relatively rare occurrence. In 1970, for instance, a malpractice incident was alleged or reported for only one out of every 158,000 patient visits to doctors, and a claim was asserted for only one out of every 226,000 patient visits. *MALPRACTICE REPORT*, *supra* note 1, at 12. *But see* notes 360-64 & accompanying text *infra* (evidence indicates that malpractice occurs much more frequently than reported).

Coupled with this breakdown in relations between the health care provider and the patient, medical consumers today are aware of their legal rights and are willing to utilize available legal channels to resolve problems. This escalating trend toward suit and claims consciousness substantially increases the potential for malpractice actions.⁸⁷

3. Insurance Nightmares

As a consequence of the substantial increase in the number of claims, the amount of the awards,⁸⁸ and the "long tail"⁸⁹ associated with malpractice occurrences, insurance rate-making during this period became an "actuarial nightmare."⁹⁰ It was difficult to develop accurate malpractice insurance rates for several reasons.

First, the medical malpractice market was extremely small.⁹¹ Moreover, the rapid increase in the number of claims and their average cost made it difficult to pinpoint any predictable pattern.⁹² Finally, a substantial period of time must elapse before the rate-maker can predict with any degree of certainty what the experi-

87. 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 5.09; MALPRACTICE REPORT, *supra* note 1, at 25; Stewart, *supra* note 13, at 134.

88. See MALPRACTICE REPORT, *supra* note 1, at 5-12; Gray, *supra* note 4, at 121; Redish, *supra* note 1, at 760-61.

89. The "long tail" is the period during which the insurance company may be held accountable for the malpractice of the insured physician occurring during the time the policy is in effect. Comment, *supra* note 1, at 659 n.28. Explanations for this "long tail" include congestion in the courts, lengthy preparation time for both plaintiff and defense attorneys, and strategic (perhaps unnecessary) delays by both parties. MALPRACTICE REPORT, *supra* note 1, at 42. Furthermore, medical injuries are unique in that the injury may not become apparent until years after the incident which caused the injury. *Id.* In many instances, the incidence of malpractice is not discovered by the patient until five or six years after the occurrence, and only 38% of all actions for medical malpractice are filed within a two year period following the malpractice incident upon which they are based. *Continuing Med. Malpractice Ins. Crisis: Hearings Before Subcomm. on Health, Comm. on Labor and Public Welfare*, 94th Cong., 1st Sess. at 192 (Dec. 3, 1975). In response to this situation most insurance companies began to issue only "claims made" policies which pay all malpractice liability on any claim made while the policy is in effect regardless of when the negligence occurred. Comment, *supra* note 1, at 659 n.28. See generally Redish, *supra* note 1; Roddis & Stewart, *supra* note 4; Steves, *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, 1975 DUKE L.J. 1305; Note, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. REV. 925 (1975).

90. Comment, *supra* note 1, at 659. See also Segar, *supra* note 5, at 130-31; Note, *Introduction: The Indiana Act in Context*, 51 IND. L.J. 91, 95 (1975). See generally Kendall & Holdi, *The Medical Malpractice Insurance Market*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 494 (Appendix).

91. See MALPRACTICE REPORT, *supra* note 1, at 41.

92. *Id.*

ence has been⁹³ because it takes an inordinate amount of time to settle a malpractice claim.⁹⁴ In addition, during the crisis, the number of claims paid and the amount paid on each of these claims increased rapidly and unpredictably.⁹⁵ For instance, if a company's average cost per claim⁹⁶ throughout a five-year period amounted to \$2,000, but suddenly a \$500,000 award was paid, the figures were no longer reliable for the purposes of projection.⁹⁷

Essentially, although the insurance premiums that were calculated in the late 1960's and early 1970's were adequate at the time, they were grossly inadequate to satisfy the tremendous increase in claims and awards several years later.⁹⁸ Rate-making became a financial risk which insurers were increasingly reluctant to assume.⁹⁹ Since intelligent rate-making was virtually impossible, insurers simply discontinued writing policies.¹⁰⁰

B. The Costs

The abrupt increase in the number of medical malpractice claims and suits exacted tremendous economic and psychological costs from the insurance industry, the health care industry and the public.¹⁰¹

1. Insurance Premiums

Although medical malpractice insurance is generally consid-

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93. *Id.* at 42.
94. See note 33 *supra*.
95. See Redish, *supra* note 1, at 759-63.
96. This would include costs for all claims since defending these claims completely through the appeals stage would amount to a substantial expense. These cases are quite simply "expensive to try and expensive to settle." Comment, *supra* note 1, at 659-60 n.29.
97. MALPRACTICE REPORT, *supra* note 1, at 43.
98. Comment, *supra* note 1, at 659.
99. See Witherspoon, *supra* note 3, at 427-28 n.43. For an excellent chart indicating how each state medical association assessed the availability of malpractice coverage in July of 1975, see MALPRACTICE IN FOCUS, *supra* note 21, at 18-20. See also Gibbs, *supra* note 4; Roddis & Stewart, *supra* note 4.
100. See Note, *supra* note 90, at 92-94. But see NAIC STUDY, *supra* note 65, at 144 (table 26) (extensive list of insurers currently writing medical malpractice insurance). Some commentators have argued that the abruptness with which the insurance industry abandoned the malpractice field was unnecessary and was based primarily on feelings of insecurity rather than an actual crisis. MALPRACTICE LIFELINE, Jan. 29, 1979, at 8. This action precipitated the panic. *Id.* But though the insurance industry was to blame for the initial miscalculations and perhaps for the speed with which they elected to substantially curtail or discontinue writing malpractice coverage, it appears that their financial losses were significant. See Segar, *supra* note 5, at 130-31. See generally MALPRACTICE REPORT, *supra* note 1, at 38-40.
101. MALPRACTICE REPORT, *supra* note 1, at 19-20.

ered indispensable to the medical profession, it was not generally available except at tremendously inflated prices.¹⁰² For instance, in the period from 1960 to 1970, premiums for physicians other than surgeons rose 540.8%¹⁰³ and those for surgeons increased 949.2%;¹⁰⁴ hospital premiums increased 262.7% in this period,¹⁰⁵ and 196% from 1974-1975 alone.¹⁰⁶ As a result, many physicians passed these increased costs on to their patients¹⁰⁷ and many elected to "go bare," i.e., carry little or no insurance coverage.¹⁰⁸ In the areas hardest hit by the crisis, some physicians quit practicing or moved into government, research or teaching positions where there was minimal exposure to suit.¹⁰⁹ Many physicians, however, initiated countersuits which further magnified the problem and in-

102. See Redish, *supra* note 1, at 760 n.4; MALPRACTICE IN FOCUS, *supra* note 21, at 18-19. See also note 5 *supra*.

103. MALPRACTICE REPORT, *supra* note 1, at 13.

104. *Id.*

105. *Id.*

106. MALPRACTICE LIFELINE, Aug. 28, 1978, at 1. But by 1977 the crisis had peaked, and it was generally recognized that there was no serious problem in any state with respect to the availability or cost of medical malpractice insurance. See Witherspoon, *supra* note 3, at 448; MALPRACTICE DIGEST, Jan./Feb. 1979, at 3-6.

107. See text accompanying note 127 *infra*.

108. Going bare was used to a much greater extent in those states with the highest premiums. For instance, in California it was estimated that approximately 20% of the physicians were going bare during the crisis. MALPRACTICE LIFELINE, Mar. 14, 1977, at 1. However, it seems clear that going bare exacts a tremendous price from the physician who lives in constant anxiety of a potential suit and consequently practices cautiously, often refusing to perform a procedure for fear of potential adverse results. MALPRACTICE LIFELINE, Oct. 24, 1977, at 4. This is because a physician practicing without insurance endangers all his personal assets everytime he treats a patient. MALPRACTICE REPORT, *supra* note 1, at 38.

In response to the number of physicians going bare, some states refuse to issue a license to practice medicine unless the health care provider has sufficient malpractice insurance. See, e.g., KAN. STAT. ANN. § 40-3402 (Cum. Supp. 1979) (every health care provider, as a condition to rendering services in the state of Kansas must maintain a policy of professional liability insurance approved by the commissioner of insurance). The provision was found to be constitutional in State *ex rel.* Schneider v. Liggett, 223 Kan. 610, 576 P.2d 221 (1978). See also KY. REV. STAT. § 304.40-330 (Supp. 1979); PA. STAT. ANN. tit. 40, § 1301.701 (Purdon Supp. 1979-80); Muranaka, *Compulsory Medical Malpractice Insurance Statutes: An Approach in Determining Constitutionality*, 12 U.S.F. L. REV. 599 (1978).

109. See MALPRACTICE IN FOCUS, *supra* note 21, at 11. But see MALPRACTICE LIFELINE, Mar. 14, 1977, at 1-2, in which a Rand Corporation study indicates that in California, one of the states with the most severe medical malpractice problems during the crisis, malpractice was neither driving physicians from the state nor discouraging new physicians from the setting up practice. Rather, health care providers were passing their costs onto their patients, or changing the scope of their practice to lower their premiums.

creased the costs.¹¹⁰

2. Defensive Medicine

Health care providers practice defensive medicine by altering their method of practice for two reasons: to diminish the potential for lawsuits by their patients, and to provide a good legal defense in the event such lawsuits are instituted.¹¹¹ Defensive medicine may involve excessive use of x-rays, diagnostic procedures, laboratory tests and patient visits, and may include unnecessary or extended hospitalization.¹¹² Although the data is inconclusive, as many as fifty to seventy percent of physicians claim they practice

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110. Many health care providers have responded to the malpractice crisis with countersuits based on charges of malicious prosecution, defamation of character and abuse of process. See Birnbaum, *Physicians Counterattack: Liability of Lawyers for Instituting Unjustified Medical Malpractice Actions*, 45 *FORDHAM L. REV.* 1003 (1977); Note, *Physician Countersuits: Malicious Prosecution, Defamation and Abuse of Process As Remedies for Meritless Medical Malpractice Suits*, 45 *U. CIN. L. REV.* 604 (1976). Since many claims have a certain amount of merit, these actions have had only a minimal impact on the malpractice problem, i.e., they have not reduced the number of claims which are made. See *MALPRACTICE LIFELINE*, June 25, 1979, at 4-8 (chart summarizing the results of most physician's countersuits throughout the nation). In addition, several recent cases seem to indicate that medical malpractice countersuits will only rarely be successful. See *Ammerman v. Newman*, 384 A.2d 637 (D.C. 1978) (attorney defendant was properly granted summary judgment in a malicious prosecution action); *Umansky v. Urquhart*, 84 Cal. App. 3d 368, 148 Cal. Rptr. 547 (1978) (abuse of process countersuit could not serve as the basis of a claim); *Berlin v. Nathan*, 64 Ill. App. 3d 940, 381 N.E.2d 1367 (1978) (physician failed to establish the required elements for a malicious prosecution case because his alleged injuries were common to all malpractice actions).

At least one legislature has given health care providers a cause of action for instigating a bad faith suit. See *TEX. REV. CIV. STAT. ANN.*, art. 4590i, § 8.02-.04 (Vernon Supp. 1980). See also Chambers, *Physician Recovery for Bad Faith Medical Malpractice Actions*, 10 *TEX. TECH L. REV.* 391 (1979); Holloway, *Malicious Prosecution Actions by the Medical Profession against Attorneys Who Unsuccessfully Pursue a Medical Malpractice Suit for a Patient*, 41 *TEX. B.J.* 421 (1978). For a general discussion of malicious prosecution, wrongful use of civil procedure and abuse of process, see *RESTATEMENT (SECOND) OF TORTS* §§ 653-74 (1977).

111. See Bernzweig, *Defensive Medicine*, reprinted in *MALPRACTICE REPORT*, *supra* note 1, at 38 (Appendix). One study classifies this type of medicine in two categories: (1) positive defensive medicine, where the health care provider uses diagnostic treatment procedures excessively, perhaps even unnecessarily, and (2) negative defensive medicine where the health care provider refuses to undertake a course of action because of fear of potential liability, even though the patient is likely to benefit from the procedure or treatment. See Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 *DUKE L.J.* 939, 942, 948-49.
112. Bernzweig, *supra* note 111, at 38-39.

defensive medicine in one form or another.¹¹³ The result is a substantial increase in the costs of medicine to consumers.¹¹⁴ Moreover, the patient is subjected to additional, often unnecessary, procedures and the physician is unable to render the highest quality of care:¹¹⁵ "[Defensive medicine's] unfortunate manifestations include the replacement of medical judgment by legal considerations, discouragement of innovations in medical practice, and the resulting impairment of medical progress. Under a defense medicine climate, research tends to become stereotyped, and ingenuity is discouraged."¹¹⁶

3. *Emotional Distress*

The costs of medical malpractice are not measured merely in economic terms, but in psychological and emotional terms as well.¹¹⁷ Health care providers, for instance, are typically stigmatized by the threat of a potential lawsuit.¹¹⁸ As one commentator noted

[T]he emotional trauma of being sued is indescribable, because one's professional conduct and competence are in question. . . . In addition, there is the realization that a finding of negligence could theoretically result in the loss of one's license to practice medicine or damage to a physician's reputation that is beyond repair.¹¹⁹

Moreover, a health care provider may experience adverse financial effects since the lawsuit demands that he spend a significant amount of time away from his practice.¹²⁰ The evidence seems to indicate that the threat of a malpractice suit is one of the major stresses of practices today.¹²¹ Even if the claims are eventu-

113. *Id.* at 39-40.

114. *Id.*

115. See MALPRACTICE REPORT, *supra* note 1, at 14-15. See also Mechanic, *supra* note 26, at 1189-92.

116. Davis, *Physician's Perspective*, 10 TEX. TECH L. REV. 333, 335 (1979).

117. *Id.* at 334; Mechanic, *supra* note 26, at 1180.

118. See Davis, *supra* note 116, at 334; Mechanic, *supra* note 26, at 1180; MALPRACTICE LIFELINE, Apr. 30, 1979, at 2.

119. Davis, *supra* note 116, at 334.

120. *Id.* But cf. Schwartz & Skolnick, *Two Studies of Legal Stigma*, 10 SOCIAL PROB. 133, 138-39 (1962) (inconclusive data indicates that sympathetic physicians may refer patients to a fellow physician who is being sued so that he does not experience tremendous financial loss).

121. See MALPRACTICE LIFELINE, Apr. 30, 1979, at 2. The feelings of many, if not most, of the members of the medical profession, were summarized by the comments made before the HEW Malpractice Commission:

Even the doctor who has never been sued is ever conscious of the sword of Damocles hanging over his head. . . . 'As a physician, I live in an aura of fear—fear of suit. Fear contributes to hostility and rarely contributes to constructive action. . . .'

....

ally denied or dropped, the health care provider has experienced an anxious and desperate experience, and he is often bitter because he feels as if he has been needlessly persecuted.¹²² This in turn only further erodes the delicate balance between the health care provider and the patient.¹²³ No longer is there a mutual feeling of trust and respect. Rather, the health care provider may view each patient as a potential adversary or hesitate in developing any channels of communication for fear of potential suit. The health care provider's impersonal attitude bewilders and frustrates the patient. Health care delivery must ultimately suffer under these circumstances, for neither the health care provider nor the patient gives maximum effort toward improving the patient's illness in the climate of distrust.

4. *Economic Effect Upon Patients*

Medical malpractice has increased the cost of health care significantly.¹²⁴ This may primarily be attributed to the health care provider's exercising defensive medicine leading to unnecessary precautionary tests and extended hospital visits.¹²⁵ And, although health care providers must pay skyrocketing premiums,¹²⁶ ultimately the patient absorbs these additional insurance costs through a direct increase in health care provider's fees or increased health care insurance premiums.¹²⁷

C. The Legislative Response

In an effort to address these problems and reduce the number and size of medical malpractice liability settlements and judgments, virtually all state legislatures enacted sweeping legislation drastically revising the medical malpractice liability system.¹²⁸ In a two year period beginning in 1975 and ending in 1976, fifty-two

It may be hard to believe, but we are a frightened profession.

MALPRACTICE REPORT, *supra* note 1, at 20 (statements of George Northup).

122. Mechanic, *supra* note 26, at 1180. See also Pabst, *supra* note 52.

123. MALPRACTICE REPORT, *supra* note 1, at 19-20.

124. *Id.* at 12-13.

125. See notes 111-16 & accompanying text *supra*. The HEW study concluded that inflation was the primary cause of rising medical care costs, accounting for 47% of the increase; nevertheless, the report found that medical malpractice has had a "significant" impact on the health care system. MALPRACTICE REPORT, *supra* note 1, at 12.

126. See text accompanying notes 102-106 *supra*.

127. See MALPRACTICE REPORT, *supra* note 1, at 12-13. See also Redish, *supra* note 1, at 759-60.

128. See ABA REPORT, *supra* note 1, at 52; T. LOMBARDI, *supra* note 2, at 118-19; *Continuing Medical Malpractice Insurance Crisis: Hearings Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare*, 94th Cong., 1st Sess. 236-45 (1975).

states and territories passed remedial medical practice legislation.¹²⁹ This legislation significantly modified many substantive or procedural aspects of tort law.¹³⁰ These legislative enactments va-

129. NAIC STUDY, *supra* note 65, at 3.

This legislation can be classified into three general categories. First, many states have formed Joint Underwriting Associations (JUAs) in order to guarantee that insurance is available for health care providers. *See, e.g.*, NEB. REV. STAT. § 44-2837 (Reissue 1978); PA. STAT. ANN. tit. 40, §§ 1301.801-810 (Purdon Supp. 1979-1980); WIS. STAT. ANN. § 655.23 (West Supp. 1979). Second, substantive and procedural modifications have been made in tort principles. *See* note 130 *infra*. *See also* provisions modifying collateral source rule, *e.g.*, FLA. STAT. ANN. § 768.50 (West Supp. 1979); IOWA CODE ANN. § 147.136 (Supp. 1979-1980); OHIO REV. CODE ANN. § 2305.27 (Page Supp. 1978); provisions limiting recoveries, *e.g.*, CAL. CIV. CODE § 3333.2 (West Supp. 1979); FLA. STAT. ANN. § 768.54(2) (West Supp. 1979); IDAHO CODE § 39-4204 (1977); IND. CODE ANN. § 16-9.5-2-2 (Burns Cum. Supp. 1979); and provisions regulating legal fees, *e.g.*, FLA. STAT. ANN. § 768.51 (West Supp. 1979); IOWA CODE ANN. § 147.138 (Supp. 1979-1980); PA. STAT. ANN. tit. 40, § 1301.604 (Purdon Supp. 1979-1980). Finally, various types of medical arbitration and screening panels were formed. For an example of legislation forming voluntary medical screening panels, see ARK. STAT. ANN. § 34-2602 (Supp. 1979). For an example of legislation forming mandatory screening panels, see FLA. STAT. ANN. § 768.44 (West Supp. 1979); IND. CODE ANN. § 16-9.5-9-2 (Burns Cum. Supp. 1979); MASS. GEN. LAWS ANN. ch. 231, § 60B (West Supp. 1979); and NEB. REV. STAT. § 44-2840 (Reissue 1978).

130. *See* ABA REPORT, *supra* note 1, at 52. For instance, this legislation imposes both direct and indirect limitations on the liability of health care providers. The direct limits may restrict the amount which the health care provider may be required to pay in the case of malpractice; *see, e.g.*, NEB. REV. STAT. § 44-2825(2) (Reissue 1978) (health care provider who qualifies under the act is not liable for any amount in excess of \$100,000); or they may also limit the plaintiff's total recovery; *see, e.g., id.* § 44-2825(1) (total amount recoverable for any injury or death may not exceed \$500,000).

Indirect limits are substantive and procedural changes in the tort system which make it more difficult for the plaintiff to recovery without directly limiting the amount which a health care provider must pay or which a patient may recover. These provisions include modifications in the doctrine of *res ipsa loquitur*; *see, e.g.*, WASH. REV. CODE ANN. § 4.24.290 (Supp. 1979) (plaintiff must prove by a preponderance of the evidence the negligence of a defendant in a medical malpractice action); limitations on the time period in which an action can be brought; *see, e.g.*, NEB. REV. STAT. § 44-2828 (Reissue 1978) (two year statute of limitations to commence action for negligence; but if cause of action could not reasonably have been discovered in two years, action can then be commenced one year from the date of discovery, but in no event later than six years from date when the service was rendered); clarification of the doctrine of informed consent; *see, e.g., id.* § 44-2816 (plaintiff's consent to treatment must be based on specific standards); limits on attorney's fees; *see, e.g., id.* § 44-2834 (on a motion, court shall review the moving party's attorney's fees and allow such compensation as is reasonable); limits on collateral source benefits; *see, e.g., id.* § 44-2819(1) (collateral insurance premiums paid to the plaintiff may be credited against the judgment); written guarantees of results; *see, e.g., id.* § 44-2818 (no liability will be imposed for assurances of results unless in writing and signed by the health care provider); elimination of the *ad damnum* clause; *see, e.g., id.* § 44-2822 (no dollar

ried widely, depending on how seriously the malpractice crisis was perceived in a particular state.¹³¹ Many states selectively modified the common-law system,¹³² while other states passed comprehensive modifications.¹³³

Nebraska enacted the Hospital-Medical Liability Act in 1976,¹³⁴ legislation patterned on the Indiana model.¹³⁵ The purpose of this legislation was twofold: (1) to assure that adequate medical care at a reasonable price was available in the state; and (2) to eliminate meritless malpractice claims and the needless expenditures of time and money in handling these claims and suits.¹³⁶ This legislation provides the exclusive remedy for patients against a health care provider for his negligence, unless the patient elects not to be bound by the terms of the act¹³⁷ or the health care provider fails to qualify under the act.¹³⁸

The following analysis discusses the two primary aspects of the

amount or figure shall be included in the demand in any malpractice petition; reasonable damages only may be requested; and alternative dispute resolution mechanisms); see, e.g., *id.* § 44-2840 to -2847 (establishment of medical review panel to review all malpractice claims). See also ABA REPORT, *supra* note 1, at 52-58; Comment, *supra* note 25, at 1417; Comment, *Testing the Constitutionality of Medical Malpractice Legislation: The Wisconsin Medical Malpractice Act of 1975*, 1977 WIS. L. REV. 838. For an excellent analysis of many of the constitutional challenges to medical malpractice legislation, see *id.*; Redish, *supra* note 1, at 769-96.

131. See ABA REPORT, *supra* note 1, at 52. The Nebraska Act generated an enormous amount of discussion and debate both in committee and on the floor. See L.B. 434/703, 84th Neb. Leg., 2d Sess., *Floor Debate* at 8580-8672, 8735-8819, 9216-28, 9441-48 (Mar. 1976); *Committee on Health & Welfare: Hearings on L.B. 434*, 84th Neb. Leg., 2d Sess. (Jan. 27, 1976).
132. See ABA REPORT, *supra* note 1, at 52.
133. See, e.g., IND. CODE ANN. § 16-9.5-1-1 to -10-5 (Burns Cum. Supp. 1979). See also Symposium, *The 1975 Indiana Medical Malpractice Act*, 51 IND. L.J. 91-168 (1975).
134. NEB. REV. STAT. §§ 44-2801 to -2855 (Reissue 1978). For a brief discussion of this act and the procedural problems it may present, see D. Lathrup, *Living and Dying with the New Medical Malpractice Act in NEBRASKA ASS'N OF TRIAL ATTORNEYS, CIVIL TRIAL PRACTICE MANUAL* § 11b (1979).
135. IND. CODE ANN. §§ 16-9.5-1-1 to -10-5 (Burns Cum. Supp. 1979).
136. NEB. REV. STAT. § 44-2801 (Reissue 1978).
137. *Id.* at § 44-2821(2). Electing to "opt out," however, may entail certain risks regarding continuing treatment by the medical community. See note 157 *infra*. Individuals are automatically covered by this legislation unless they choose to forego coverage by filling out certain forms which they file with the director of insurance. The patient must also notify the health care provider of his decision prior to treatment. Since this legislation may significantly affect future rights, it seems imperative that a patient be properly notified of his right to opt out. However, section 44-2821(4) requires only that the health care provider post a sign, in a suitable location, stating he has qualified under the Act. See also *Lincoln Journal & Star*, July 22, 1979, § B, at 1, col. 1 (only 41 Nebraskans have elected not to be covered by the Act).
138. NEB. REV. STAT. § 44-2821(1) (Reissue 1978).

Nebraska legislation: the tort law modifications and the pretrial screening panel. These provisions are addressed because they deprive malpractice patients of many of their common law rights, while providing little or no commensurate benefit. They place patients who experience malpractice at a serious disadvantage and consequently warrant evaluation in an atmosphere unlike the urgent situation in which they were developed.

III. THE NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

A. Tort Law Modifications

The proponents of medical malpractice legislation intended to reduce the scope of risk for health care providers by modifying numerous tort doctrines. These substantive and procedural changes were designed to reduce the number of individuals entitled to make a claim and limit the recovery of those parties with valid claims. By reducing the number and size of medical liability settlements and judgments, the drafters hoped that insurance premiums would be reduced so that adequate insurance would be available at reasonable prices.

1. *Limitations on Awards*

a. *Ceilings on Recovery*

The most direct method of controlling insurance premiums is to limit the amount which the health care provider¹³⁹ is required to pay and which the plaintiff is entitled to recover.¹⁴⁰ As a result, medical negligence theoretically becomes insurable at a reasonable rate. The Nebraska Hospital-Medical Liability Act incorpo-

139. The term health care provider is defined in the Act:

Health care provider shall mean (a) a physician; (b) a nurse anesthetist; (c) an individual, partnership, corporation, association, facility, institution, or other entity authorized by law to provide professional medical services by physicians or nurse anesthetists; (d) a hospital, or (e) a personal representative as defined in subdivision (33) of section 30-2209, who is successor or assignee of any health care provider designated in subdivisions (a) to (d) of this subsection.

NEB. REV. STAT. § 44-2803(1) (Reissue 1978). It is unclear why nurses, dentists and oral surgeons were excluded from this definition. This will certainly result in difficulties when a physician and attending nurse are both charged with malpractice, since the patient will be forced to proceed against the physician under the Act, but must resort to common law remedies when proceeding against the nurse. This is a significant oversight because nurses are frequently implicated for having contributed to the injury. See, e.g., NAIC STUDY, *supra* note 65, at 125-26 (table 18) (registered nurses contribute to the patient injury in approximately 14% of claims made against hospitals). For a more comprehensive definition of health care provider, see IND. CODE ANN. § 16-9.5-1-1(a) (Burns Cum. Supp. 1979).

140. See Comment, *supra* note 1, at 666-68; Comment, *supra* note 25, at 1418-20.

rates both of these techniques, placing a \$500,000 ceiling on the amount which the plaintiff can recover¹⁴¹ and limiting the liability of a qualifying health care provider to \$100,000 for all causes of action arising from any malpractice occurrence.¹⁴² To qualify under the Act, the health care provider must file proof of his financial responsibility with the Director of Finance in the amount of at least \$100,000 for each occurrence and pay a surcharge into the Excess Liability Fund.¹⁴³ Any amount due from a judgment settlement which is in excess of the total liability from all liable health care providers is to be paid from this Excess Liability Fund.¹⁴⁴ These provisions are intended to ensure that most victims actually receive compensation, and to spread the costs among health care providers throughout the state.¹⁴⁵

This abrogation of the common law right to full compensation has been constitutionally challenged on numerous occasions.¹⁴⁶ The majority of courts have sustained provisions similar to these, but the Supreme Courts of Illinois¹⁴⁷ and North Dakota¹⁴⁸ invali-

141. "The total amount recoverable under [the Act] from *any and all health care providers* and the Excess Liability Fund for *any occurrence* resulting in *any injury or death* of a patient may not exceed five hundred thousand dollars." NEB. REV. STAT. § 44-2825(1) (Reissue 1978) (emphasis added).

142. "A health care provider qualified under [the Act] shall not be liable to any patient or his representative . . . for an amount in excess of one hundred thousand dollars for *all* claims or causes of action arising from *any* occurrence . . ." *Id.* § 44-2825(2).

The total amount for which a health care provider may be held liable for all occurrences or claims made in any policy year for each named insured is \$300,000, and in the case of hospitals, the aggregate liability is \$1,000,000. *Id.* § 44-2824(1).

143. *Id.* §§ 44-2824, -2827.

144. The Director of Insurance administers this fund which is held in trust for the purpose of satisfying judgments in excess of \$100,000. *Id.* § 44-2829(1). The director levies an annual surcharge on all qualified health care providers subject to two limitations: (1) the surcharge shall not exceed 50% of the annual premium paid by the health care provider in order to maintain his current financial responsibility, and (2) the charge will not exceed the amount necessary to maintain the fund at an approximate level of five million dollars. *Id.* §§ 44-2829(2), -2830. Additional procedural requirements are found in sections 44-2829(3), (6), and 44-2831 of the Act.

145. See Comment, *supra* note 25, at 1418-25.

146. For cases invalidating statutory ceilings on recovery, see *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Graley v. Satayatham*, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (Ohio 1976); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976). But see *Jones v. State Bd. of Medicine*, 97 Idaho 859, 555 P.2d 399, cert. denied, 431 U.S. 914 (1976); *Prendergast v. Nelson*, 199 Neb. 97, 256 N.W.2d 657 (1977). See also Annot., 80 A.L.R.3d 583 (1977) (*Validity and Construction of State Statutory Provisions Relating to Limitations on Amount of Recovery in Medical Malpractice Claim and Submission of Such Claim to Pretrial Panel*).

147. *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

dated statutes placing a ceiling on recoverable damages.

In *Wright v. Central Du Page Hospital Association*,¹⁴⁹ the Illinois Supreme Court considered the constitutionality of Illinois legislation placing a \$500,000 ceiling on recoverable damages. The court concluded the monetary limit on recovery violated the Illinois constitutional prohibition against special legislation since recovery was denied on an arbitrary basis (the restrictions applied only to medical malpractice cases).¹⁵⁰

The North Dakota Supreme Court in *Arneson v. Olson*¹⁵¹ also invalidated North Dakota's statutory ceiling of \$300,000 in medical malpractice cases, but for reasons distinct from those relied on in *Wright*. The court held that the provision violated the equal protection clauses of the federal and state constitutions,¹⁵² and questioned whether the legislation actually achieved its intended purpose:

Certainly the limitation of recovery does not provide adequate compensation to patients with meritorious claims; on the contrary, it does just the opposite for the most seriously injured claimants. It does nothing toward the elimination of nonmeritorious claims. Restrictions on recovery may encourage physicians to enter into practice and remain in practice, but do so only at the expense of claimants with meritorious claims.¹⁵³

However, in *Prendergast v. Nelson*¹⁵⁴ the Nebraska Supreme Court concluded that the \$500,000 limit on damages under the Nebraska Medical Liability Act was valid.¹⁵⁵ This was a declaratory judgment action initiated to determine the constitutionality of the Nebraska Act after the defendant, the Director of Insurance, refused to implement the Act. The defendant argued that the \$500,000 ceiling on judgments constituted "a special privilege for the health care provider and an undue restriction on the seriously injured patient."¹⁵⁶ The court concluded, however, that the Nebraska provision withstood these challenges for several reasons.

148. *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978).

149. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

150. *Id.* at 329-30, 347 N.E.2d at 743. The court concluded that while it was not necessary when abolishing a common law cause of action to always provide a concomitant *quid pro quo*, such action will be invalid when it is done on an arbitrary basis. *Id.* at 329, 347 N.E.2d at 743.

151. 270 N.W.2d 125 (N.D. 1978).

152. *Id.* at 136.

153. *Id.* at 135-36.

154. 199 Neb. 97, 256 N.W.2d 657 (1977).

155. *Id.* at 114-15, 256 N.W.2d at 668-69.

156. *Id.* Essentially the defendant alleged that specific provisions of the act (medical review panel, statute of limitations, and limitations on recovery and liability) operated to single out a class of persons (health care providers) for special treatment, action which had no rational relationship to a legitimate state purpose. However, the court looked to the legislative purpose of the act and concluded that this classification was reasonable, citing a standard out-

First, a patient may elect not to be bound by the terms of the Act (1) by filing his decision not to be bound with the Director of Insurance *prior* to any treatment or action by the health care provider, and (2) by notifying the health care provider of this decision as soon as is reasonable under the circumstances.¹⁵⁷ Second, the plaintiff receives several additional benefits under the Act. For instance, the claimant is guaranteed an assured fund of \$500,000 for

lined in an earlier medical malpractice decision, *Taylor v. Karrer*, 196 Neb. 581, 244 N.W.2d 201 (1976):

The Legislature may make a reasonable classification of persons, corporations, and property for purposes of legislation concerning them, but the classification must rest upon real differences of situations and circumstances surrounding the members of the class relative to the subject of the legislation which render appropriate its enactment. . . . While it is competent for the Legislature to classify for purposes of legislation, the classification, to be valid, must rest on some reason of public policy, some substantial difference of situation or circumstance, that would naturally suggest that justice or expediency of diverse legislation with respect to the objects to be classified. In holding there was some reason of public policy, some substantial difference of situation or circumstance, that naturally suggested the justice or expediency of the legislation with respect to malpractice actions, we there said: 'There are substantial reasons for legislative discrimination in regard to this field [malpractice]. We have seen in recent years the growth of malpractice litigation to the point where numerous insurance companies have withdrawn from this field. Insurance rates are practically prohibitive so that many professional people must either remain unprotected or pass the insurance charges along to their patients and clientele in the form of exorbitant fees and charges. This unduly burdens the public which requires professional services.'

199 Neb. at 112-13, 256 N.W.2d at 667-68. *But see id.* at 129-32, 256 N.W.2d at 675-77 (White, J., dissenting) (section 44-2825 is clearly unconstitutional as special legislation).

157. NEB. REV. STAT. § 44-2821 (Reissue 1978). There is a question, however, whether health care providers would be willing to accept a patient if they suspect that he is more likely to instigate a malpractice suit, or if the patient is seen as an unusual risk:

The majority opinion's partial reliance on the elective provisions of the act is misplaced. The reality of the freedom to elect by a claimant was not considered and is not easily demonstrable. Such an election provision ignores the inequality of bargaining power. The very nature of a person's status as a patient places him in a position which makes effective bargaining difficult. A right to elect not to be covered, from which might result a denial of service from the only hospital or physician in a geographical area, can hardly be said to be without implicit coercion. The consideration that the election may result in termination of services, or refusal by health care providers to give service, because of knowledge that the patient has previously filed a notice with the state Department of Insurance not to be covered, will cause a thoughtful person to use caution in exercising the right,

Prendergast v. Nelson, 199 Neb. at 132, 256 N.W.2d at 676-77 (White, J., dissenting).

the payment of any malpractice claim he presents. Under the common law system of recovery, a patient had no such guarantee, and his chances of collecting a substantial judgment against an uninsured or minimally insured health care provider were remote. In addition, the court concluded that "the claimant is assured of a procedure which will provide him access to an impartial medical review panel to determine whether the health care provider met the applicable standard of care. In return, claimant by his election agrees to the \$500,000 ceiling."¹⁵⁸

Although this direct method of limiting recoveries contains the "virtue of simplicity,"¹⁵⁹ it raises questions of basic fairness that are not easily answered. The initial problem is that seriously injured patients are denied full compensation for their injuries when they exceed the \$500,000 limit. Traditionally in tort, the party at fault is responsible for his conduct. Legislation such as Nebraska's, which places a limit on the amount the injured party is allowed to recover and the negligent party is required to pay, shifts this burden of paying for the wrong onto the injured party in instances where the injury exceeds \$500,000. The most seriously injured parties—those with injuries in excess of \$500,000—are denied the opportunity to be made whole. And although only a very small percentage of the victims of medical malpractice will sustain economic losses exceeding \$500,000,¹⁶⁰ it is these most seriously injured individuals who desperately need compensation proportionate to their actual loss:

The burden cast upon patients injured by medical malpractice who suffer damages in excess of the \$500,000 limitation could be catastrophic. . . . For example, unless the patient who is a human vegetable as a result of malpractice can be compensated for the full actual damages suffered, the patient will be denied income, relationships, and quality of life to the extent that full damages would have made this possible. Moreover, it is likely

158. 199 Neb. at 115, 256 N.W.2d at 669. It is important to note that the panel consists of one non-voting attorney and three physicians. See text accompanying note 281 *infra*. This may represent a significant advantage for the plaintiff since "either party shall have the right to call any member of the medical review panel as a witness" in subsequent actions. NEB. REV. STAT. § 44-2844(2) (Reissue 1978). With medical testimony readily available, the plaintiff is no longer burdened by the "conspiracy of silence" among health care providers. See note 345 *infra*.

159. Comment, *supra* note 1, at 667.

160. Few awards exceed \$100,000. In 1970, for instance, statistics indicated that \$3,000 was the median recovery in medical malpractice actions and that 97% of all awards are for less than \$100,000. MALPRACTICE REPORT, *supra* note 1, at 10 (table 7 at 11). See also Comment, *supra* note 25, at 1419-20. But see NAIC STUDY, *supra* note 65, at 131-34 (tables 22a-c) (summary of 16,500 claims closed since July 1976 indicates that the average indemnity paid for each malpractice claim had risen to \$7,238.00). See also *id.* at 148 (table 27) (only three reported cases in Nebraska in a two year period from June 1976 to June 1978 where the amount of indemnity paid for the defendant was \$50,000 or more).

that the person whose injuries are in excess of \$500,000 is the person least able to bear the burden of those damages. In such a case the family of the injured patient must bear the burden of the damages as well as the loss of the patient's consortium. While it is rare that patients will suffer such catastrophic damages as a result of medical and health care malpractice, these patients are not less important to society than other patients. The need for compensation for actual damages suffered in a catastrophic injury due to medical malpractice is great, and that need is more compelling when, the patient's family is unable to shoulder that loss.¹⁶¹

It also seems unlikely, since malpractice awards in excess of \$500,000 are a rare occurrence,¹⁶² that such limitation will have any significant effect on guaranteeing that malpractice insurance is available at reasonable rates.¹⁶³ There could not be any substantial reduction in costs since the ceiling effects only a very few cases. The most seriously injured parties, however, must bear the burden of these limits, and these individuals are often least able to sustain such a burden. This merely adds insult to injury, for not only is the patient injured by the negligence of the health care provider, he is unable to attain full compensation for his injury.¹⁶⁴

In spite of the fact that Nebraska's limitation on recovery has weathered constitutional challenge, it deserves further evaluation. It is designed to reduce the cost of malpractice, but it is unlikely that it will have any significant impact. The costs of malpractice have merely been shifted from the health care provider and public to the most seriously injured, an allocation which seems grossly inequitable.

*b. Modification of Collateral Source Rule*¹⁶⁵

Another method of limiting malpractice awards has been to

161. Witherspoon, *supra* note 3, at 442 n.115.1. See also W. SCHATZ & N. KOMESAR, DOCTORS, DAMAGES, AND DETERRANCE: AN ECONOMIC VIEW OF MEDICAL MALPRACTICE (Rand Corp. 1978); Comment, *Alternatives to the Medical Malpractice Phenomenon: Damage Limitations, Malpractice Review Panels and Countersuits*, 34 WASH. & LEE L. REV. 1179, 1182-86 (1977); Note, *The Indiana Medical Malpractice Act: Legislative Surgery on Patients' Rights*, 10 VAL. U. L. REV. 303, 313-38 (1976).

162. See note 160 *supra*.

163. *But cf.* Comment, *supra* note 1, at 668 (direct limitations on the amount of awards may fulfill the purpose of making health care providers more insurable). Such limitations on the amount awarded may also lead to more accurate calculations and predictions by the insurance industry. See text accompanying notes 94-97 *supra*.

164. See Abraham, *supra* note 2, at 504.

165. For analysis of the collateral source rule in general, see Mocerri & Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZ. L. REV. 310 (1972); Schwartz, *The Collateral-Source Rule*, 41 B.U. L. REV. 348 (1961); Note, *Unreason in the Law of Damages: The Collateral Source Rule*, 77 HARV. L. REV. 741 (1964). For analysis of the collateral source rule in the context of medical malpractice, see Comment, *Recent Developments in Medical*

modify the collateral source rule. Under the collateral source rule, any benefits (government benefits, wage compensation, insurance proceeds, or even payments from friends or relatives) which the injured party receives may not be used to offset the judgment.¹⁶⁶ This rule, which has been accepted by most states,¹⁶⁷ "excludes evidence of collateral source benefits and prevents any reduction of damages because of such payments."¹⁶⁸

The Nebraska Act provides that the benefits of any non-refundable medical insurance reimbursement, less all premiums paid, may be credited against the final judgment, but evidence of such insurance is inadmissible at trial.¹⁶⁹ The purpose of this is to prohibit the plaintiff from a double recovery, *i.e.*, recovery from both the negligent health care provider and the collateral source.¹⁷⁰ Although some states have gone further than Nebraska by admitting evidence of alternative sources of compensation at trial,¹⁷¹ the result is essentially the same, *i.e.*, collateral compensation is now subtracted from the amount for which the negligent health care provider is liable.¹⁷² By thus reducing the amount for which the negligent health care provider is held responsible, overlapping payments are reduced, but the victim is fully compensated for his losses if less than \$500,000. Moreover, under the provision which

Malpractice Law, 1977 ARIZ. ST. L.J. 163, 192-97; Comment, *supra* note 25, at 1447-50.

166. Comment, ARIZ. ST. L.J., *supra* note 165, at 192-93; Comment, *supra* note 25, at 1447.

167. Mocerri & Messina, *supra* note 165, at 315.

168. Comment, *supra* note 25, at 1447.

169. In any action for damages for bodily injury or wrongful death . . . , evidence which tends to establish that the claimant or another person so damaged has been or shall be reimbursed or paid for any such item of damage, cost, or expense, in whole or in part, by any nonrefundable medical reimbursement insurance *shall not be admissible in evidence* or brought to the attention of the jury, but such nonrefundable medical reimbursement insurance benefits, less all premiums paid by or for the claimant *may be taken as a credit against any judgment rendered*.

NEB. REV. STAT. § 44-2819(1) (Reissue 1978) (emphasis added).

The Act also defines the scope of damages: "Damages recoverable in any action shall be those losses which have been or shall be sustained by the claimant as a direct and proximate result of the defendant's wrongful acts as established by a preponderance of the evidence." *Id.* § 44-2819(2).

170. See Comment, *supra* note 1, at 669. See also Comment, *The Texas Collateral Source Rule: A Critical Survey*, 54 TEX. L. REV. 791 (1976).

171. Nebraska's provision abrogates the collateral source rule as a rule of damages but retains it as a rule of evidence. See note 169 *supra*. See also Comment, *supra* note 25, at 1447-50. Another alternative has been suggested in which the insurer of the defendant provider is liable to the source of the collateral benefits, usually a first party medical insurer or disability insurer. *Id.* at 1449.

172. Comment, *supra* note 1, at 669.

subtracts the premium payments, the individual should be made completely whole because he may have incurred expenses in paying for the collateral source of income such as insurance premiums. It seems only reasonable that the plaintiff should receive credit for these expenses, and several legislatures have enacted provisions similar to Nebraska's.¹⁷³

It appears that modifying the traditional collateral source rule may have a "measurable impact on premium costs" since the costs of malpractice awards will be shifted to private and government insurance programs.¹⁷⁴ As the amount which insurance companies pay is reduced, there should be a corresponding reduction in the amount of premiums health care providers must pay. For example, one study indicated that malpractice awards would be reduced ten to twenty percent by eliminating the collateral source rule.¹⁷⁵ Moreover, the injured party is not penalized for his foresight¹⁷⁶ since he pays for the collateral source benefits to provide security for his injuries rather than to provide double recovery.¹⁷⁷ To allow additional recovery after the injured party's loss has been fully compensated burdens society substantially since these payments result in increased malpractice premiums, costs which the

173. See, e.g., KAN. STAT. ANN. § 60-471(b) (1976); R.I. GEN. LAWS § 9-19-34 (Supp. 1978).

174. ABA REPORT, *supra* note 1, at 56. However, it seems reasonable to conclude that insurers will intervene and exercise a right of subrogation, thus holding the negligent health care provider or his insurer liable for the full recovery. This would appear to frustrate the purpose of allowing the set off (reducing the amount which the health care providers ultimately pay in order to minimize insurance costs). See Comment, *supra* note 1, at 669.

175. ABA REPORT, *supra* note 1, at 56-57. This study indicated, however, that there are several factors which may limit the premium reductions to be gained by eliminating the collateral source rule. The most important of these seems to be that insurers are unlikely to reduce premiums until the statistics over several years indicate that the amounts which they must pay have been reduced by abrogating the collateral source rule. Additionally, it may be relevant that the language of the Nebraska provision is not mandatory ("may be taken as credit") which indicates that the judge or jury may have some discretion in this regard. Cf. OHIO REV. CODE ANN. § 2305.27 (Page Supp. 1978) (specific guidelines when collateral source payments "shall" and "shall not" be credited against a judgment).

176. This is one of the most common explanations given for preserving the collateral source rule. Since the plaintiff has paid for the benefits, he should be the one to profit from them. See, e.g., *Gypsum Carrier, Inc. v. Handelsman*, 307 F.2d 525, 534-35 (9th Cir. 1962): "Collateral source funds are usually created through the prudence and foresight of persons other than the tortfeasor, frequently including the injured person himself. They are intended for the benefit of the injured person and not for that of the person who injures him. That intention should be effectuated." See also Mocerri & Messina, *supra* note 165, at 315-16.

177. See Comment, *supra* note 25, at 1448-49.

health care provider passes on to patients.¹⁷⁸ It seems reasonable, therefore, that the measure of the plaintiff's damages should be that amount which is sufficient to compensate him for his losses and his out-of-pocket expenses in purchasing the collateral benefits.¹⁷⁹

In *Prendergast*, the defendant charged that the provision in the Nebraska Act which gives credit for collateral sources impaired the obligation of contract in contravention of the Nebraska Constitution.¹⁸⁰ The court rejected this argument, stating that a party may elect whether or not to be covered by the Act.¹⁸¹ Moreover, the court reasoned that this provision was intended to eliminate possible windfall profits resulting from double recovery and serves a legitimate state purpose.¹⁸²

c. *Elimination of the Ad Damnum Clause*

The *ad damnum* clause is that portion of the petition in which the plaintiff sets forth the amount of recovery sought.¹⁸³ Its primary use is to establish the court's jurisdiction,¹⁸⁴ but it also places the defendant on notice of the amount of recovery the plaintiff is requesting¹⁸⁵ and limits the amount which the plaintiff may recover in cases where the defendant defaults.¹⁸⁶ Where the defendant actively defends, the plaintiff is generally free to amend the amount requested and the jury is free to award any amount in

178. *Id.* at 1449.

179. If the health care provider's conduct is wanton or malicious the patient may find additional recourse by complaining to the medical qualifications committee. NEB. REV. STAT. §§ 44-2848 to -2853 (Reissue 1978). Punitive damages, however, are not allowed in Nebraska in cases involving private parties. *See, e.g., Miller v. Kingsley*, 194 Neb. 123, 230 N.W.2d 472 (1975).

180. 199 Neb. at 115-16, 256 N.W.2d at 669. Specifically, the plaintiff alleged that this legislation violated NEB. CONST. art. I, § 16, which provides: "No . . . law impairing the obligation of contracts . . . shall be passed."

181. *But see* note 157 *supra*. Compare *Eastin v. Broomfield*, 116 Ariz. 576, 570 P.2d 744 (1977) (abolition of the collateral source rule as it affects medical malpractice was sustained against attacks that it was unconstitutional as special legislation, a limitation on damages, and a denial of equal protection and due process) with *Graley v. Satayatham*, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1976) (statute modifying the collateral source rule in malpractice actions declared unconstitutional).

182. 199 Neb. at 116, 256 N.W.2d at 669. *But see id.* at 129, 256 N.W.2d at 675 (section 44-2819 is "clearly unconstitutional as special legislation. . . . This is a significant deviation from the total concept of restitution in that the negligent may escape paying for the portion of damages he causes.") (White, J., dissenting).

183. *See* BLACK'S LAW DICTIONARY 56 (rev. 4th ed. 1968). *See also* Comment, *supra* note 25, at 1451.

184. *See* Comment, *supra* note 25, 1451-52.

185. Comment, ARIZ. ST. L.J., *supra* note 165, at 190-91.

186. *Id.* at 191.

excess of the request.¹⁸⁷ The statement of a dollar amount in *ad damnum* clauses seems to serve no important purpose in a contested case and provides little special benefit to the plaintiff. The *ad damnum* clause "is the equivalent of an asking price and frequently bears little resemblance to actual damages."¹⁸⁸ However, when an injured patient demands an astronomical amount, this generates tremendous adverse publicity for the medical profession and the public is often deceived into thinking that such awards are commonplace and an appropriate measure of damages.¹⁸⁹

[T]he astronomical amounts of damages set forth in malpractice complaints by attorneys are an unnecessary source of friction between the legal and medical professions. These large demands attract sensational newspaper coverage, impose needless anxiety and often unfounded notoriety upon defendant physicians, create a feeling of unfair persecution in the medical world and are of no special benefit to the plaintiff-patients.¹⁹⁰

Additionally, studies seem to indicate that a request for substantial damages often results in a higher verdict.¹⁹¹ Consequently, under the Nebraska Act the plaintiff is entitled to ask only for "reasonable" damages and not for damages in any stated amount.¹⁹² Similar provisions eliminating the *ad damnum* clause have been enacted in other states,¹⁹³ and there have been very few

187. *Id.*

188. Comment, *supra* note 25, at 1452.

189. *Id.* See also Comment, *supra* note 1, at 669-70.

190. MALPRACTICE REPORT, *supra* note 1, at 38. Although the overall influence of the media is not exactly clear, an extensive study conducted by the HEW Medical Malpractice Commission in 1973 made several conclusions which would seem to indicate that the media's role is substantial. For instance, the study indicated that the depth of coverage of a malpractice incidence was largely dependent upon "human interest" values, such as the involvement of a large amount of money, the sad plight of a severely injured person, or sexual misconduct." *Id.* at 19. But the commission also concluded that "[d]espite isolated instances of emotionalism, bias and inaccuracy, press, radio and television coverage of medical malpractice cases and problems is, on the whole, straightforward, factual and balanced." *Id.* See also Byrnes, *Media and Medical Malpractice*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 653 (Appendix).

191. Comment, *supra* note 25, at 1452. See generally Broeder, *The University of Chicago Jury Project*, 38 NEB. L. REV. 744, 759 (1959).

192. NEB. REV. STAT. § 44-2822 (Reissue 1978) provides: "No dollar amount or figure shall be included in the demand in any malpractice petition or complaint, but the petition shall ask for *such damages as are reasonable* in the premises." (emphasis added).

193. See, e.g., FLA. STAT. ANN. § 768.042 (West Supp. 1979); IND. CODE ANN. § 16-9.5-1-6 (Burns Supp. 1979); IOWA CODE ANN. § 619.18 (West Supp. 1979-1980); LA. REV. STAT. ANN. § 40.1299.41(E) (West 1977); MASS. GEN. LAWS ANN. ch. 231, § 60C (West Supp. 1979); OHIO REV. CODE ANN. § 2307.42(C) (Page Supp. 1978); WIS. STAT. ANN. § 655.009(1) (West Supp. 1979). See also NEB. REV. STAT. § 25-804 (Reissue 1976).

challenges to this legislation.¹⁹⁴ Its elimination is to be applauded since it had long outlived any useful purpose and its adverse consequences far outweighed whatever benefit such a provision may have served.

2. Statute of Limitations

When evidence and witnesses are no longer available defendants should be entitled to assurances that they no longer must defend claims stemming from earlier conduct.¹⁹⁵ Traditionally, therefore, restrictions have been imposed upon the time during which a potential claim could be initiated.¹⁹⁶ In the context of most tort actions, this time period commences "on the date of the alleged act or omission which forms the basis for the claim, regardless of the plaintiff's knowledge of his injury."¹⁹⁷

In the medical malpractice field, however, the courts have developed numerous exceptions to this rule in an attempt to alleviate the harshness of the limitation in cases where the plaintiff has in good faith failed to make a timely discovery of his claim.¹⁹⁸ There are four common exceptions to the statute of limitations employed in medical malpractice actions. First, the plaintiff may plead the cause of action as a breach of contract and consequently take advantage of the longer statute of limitations for contract actions as opposed to the much shorter period for tort actions.¹⁹⁹ Second, the fraudulent concealment exception may apply when the health care provider knowingly and willfully conceals errors when treating the patient. In this case the applicable statute of limitations does not

194. *But see* Everett v. Goldman, 359 So. 2d 1256, 1266 (La. 1978) (proscription against *ad damnum* clauses will have a beneficial effect in reducing malpractice awards and is rationally related to a legitimate state interest). Section 44-2822 was not addressed by the court in *Prendergast*.

195. *Developments in the Law—Statutes of Limitations*, 63 HARV. L. REV. 1177, 1185 (1950).

196. Comment, *supra* note 25, at 1429.

197. *Id.*

198. These exceptions may apply in only a small number of cases, since the clear majority of all claims (79.1% according to the NAIC STUDY, *supra* note 65, at 15 (table 1a, 2a)) are reported in the first two years. This study also found that after five years, approximately 97% of all claims have been reported. *Id.*

199. Comment, *supra* note 25, at 1430. Compare NEB. REV. STAT. § 25-205 (Reissue 1975) (action on a written contract must be brought in five years) and § 25-206 (action on an oral contract must be brought in four years) with § 25-208 (action for malpractice must be brought in two years). *But see* Comment, *supra* note 25, at 1430 n.61, which indicates that causes of action for malpractice which are based on a breach of contract theory are disfavored by the courts and are used infrequently by patients. Additionally, the Nebraska Act provides that no liability will be imposed on any health care provider based on a breach of a contract assuring results unless such contract is "expressly set forth in writing." NEB. REV. STAT. § 44-2818 (Reissue 1978).

begin to run until the fraud is evident.²⁰⁰ Third, the termination rule exception may apply when a health care provider continues treating a patient after making an error, but fails to discover it.²⁰¹ In this situation, the health care provider is deemed negligent initially and for the entire treatment period, so the statute of limitations does not begin to run until the patient's relationship with the health care provider is terminated. Fourth, the discovery rule exception may apply. In this case the statute of limitations does not commence to run until the patient actually discovers, or through the exercise of reasonable care should have discovered the injury.²⁰²

Health care providers argue that these exceptions expose them

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200. Comment, *supra* note 25, at 1430-31. The reason for this exception is that there is no longer any need to protect defendants from unreasonably long delays in filing lawsuits, since the health care provider is responsible for the delay. 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 13.11. Generally, affirmative acts beyond mere silence by the health care provider are necessary, especially where the silence is due to an honest mistake. *Id.* For cases addressing aspects of the affirmative burden which the plaintiff must sustain in order to prevail on a fraudulent concealment allegation, see *Nardone v. Reynolds*, 333 So. 2d 25 (Fla. 1976); *Millett v. Dumais*, 365 A.2d 1038 (Me. 1976); *Dyke v. Richard*, 40 Mich. App. 115, 198 N.W.2d 797 (1972), *rev'd on other grounds*, 390 Mich. 739, 213 N.W.2d 185 (1973); *Monroe v. Harper*, 164 Mont. 23, 518 P.2d 788 (1974); *Sanchez v. Wade*, 514 S.W.2d 812 (Tex. 1974). See also CAL. CIV. PROC. CODE § 340.5 (West Supp. 1979) (intentional concealment tolls the statute of limitations in a malpractice action against a health care provider); Annot., 80 A.L.R.2d 368, 401 (1961); Note, *Tort Law—Statute of Limitations in Medical Malpractice Actions*, 1970 Wis. L. Rev. 915, 918.
201. Comment, *supra* note 24, at 1431. See *Camire v. United States*, 535 F.2d 749 (2d Cir. 1976) ("continuing treatment" theory requires treatment by same physician, associate or hospital; it does not apply where diagnosis and treatment involved separate hospital and physicians); *Davies v. Reese*, 197 Neb. 320, 248 N.W.2d 344 (1977) (where physician repeatedly assures patient that breast is not cancerous but fails to conduct the proper tests, statute of limitations begins to run as of date of final negligent diagnosis); *Toman v. Creighton Memorial St. Josephs Hosp., Inc.*, 191 Neb. 751, 217 N.W.2d 484 (1974) (statute tolled during postoperative period where surgeon repeatedly assures patient that she is recovering and keeps recommending further therapy); 1 LOUISELL & WILLIAMS, *supra* note 78, ¶¶ 13.08-09. See also Comment, *supra* note 25, at 1431 n.65.
202. Comment, *supra* note 25, at 1431-32. See *Reilly v. United States*, 513 F.2d 147 (8th Cir. 1975) (statute begins to run when symptoms become so grave as to alert a reasonable person that her treatment may have been negligent); *Toman v. Creighton Memorial St. Josephs Hosp., Inc.*, 191 Neb. 751, 217 N.W.2d 484 (1974) (statute does not commence to run until the malpractice and resulting injury is, or by the use of reasonable diligence could be, discovered). See also 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 13.07; Comment, *Statute of Limitations—Malpractice—Discovery Rule Applied to External Injuries—Fraudulent Concealment and the Treating Physician's Duty to Disclose*, 25 RUTGERS L. REV. 711 (1971); Note, *Physicians—Applying the Statute of Limitations in Malpractice Cases*, 42 NEB. L. REV. 180 (1962).

to perpetual liability regardless of when the incident occurred.²⁰³ Moreover, the insurance industry, which during the period preceding the crisis sold malpractice insurance on an occurrence basis,²⁰⁴ claimed that because of the extended statute of limitations, the potential period of risk was indeterminate.²⁰⁵ Consequently, insurance companies claimed that effective rate-making was virtually impossible and that they were being forced to maintain huge reserves to protect themselves from claims filed many years after the malpractice.²⁰⁶ As insuring health care providers became more uncertain, fewer insurance companies were willing to assume the risk and many began to withdraw from this area.²⁰⁷

In response, legislatures limited the time periods in which to file a malpractice claim in order to reduce the health care provider's potential liability. Some of these provisions were excessively harsh, penalizing the injured victims while immunizing health care providers.²⁰⁸ A few provisions, for instance, created an absolute statutory time limit in which the plaintiff could initiate an action, barring causes of action filed after the time had elapsed without regard to their validity.²⁰⁹ Nevertheless, these provisions imposing restricted statutes of limitations have generally withstood constitutional challenge.²¹⁰

203. Comment, *supra* note 25, at 1429.

204. See note 89 *supra*.

205. See Redish, *supra* note 1, at 765; Comment, *supra* note 1, at 1429. See also notes 88-100 & accompanying text *supra*.

206. See Comment, *supra* note 1, at 1429. See generally Roddis & Stewart, *supra* note 4.

207. See notes 88-100 & accompanying text *supra*.

208. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4590i, § 10.01 (Vernon Supp. 1980) (absolute two year statute of limitations which cuts off the patient's right to commence a medical malpractice claim two years after the occurrence of the malpractice). This provision apparently applies although the patient did not know, and could not reasonably have discovered within the two year period that he had suffered a medical injury due to malpractice. For an excellent critical analysis of this provision, see Witherspoon, *supra* note 3, at 426-38. In addition to arbitrarily barring individuals who have a legitimate claim but have been unable, after exercising due diligence, to discover their injury, this absolute statute of limitations may result in individuals filing suits prematurely on the contingency that a basis for a cause of action might appear at some future time. Comment, *supra* note 24, at 1434 n.81. See also Note, *A Four Year Statute Of Limitations For Medical Malpractice Cases: Will Plaintiff's Case Be Barred?*, 2 PAC. L.J. 653 (1971).

209. Comment, *supra* note 1, at 673.

210. See, e.g., Landgraaf v. Wagner, 26 Ariz. App. 49, 546 P.2d 26, *appeal dismissed*, 429 U.S. 806 (1976) (six year statute of limitations relating to malpractice actions against health care providers neither denies due process or equal protection nor constitutes special legislation); *Foley v. Morris*, 339 So. 2d 215 (Fla. 1976) (legislature has authority to adopt a statute of limitations which retroactively shortens a period of limitation, provided a reasonable time is allowed to file the suit); *Taylor v. Karrer*, 196 Neb. 581, 244 N.W.2d 201 (1976) (since

The Nebraska Act provides a short statutory period (two years) in which all malpractice actions must be commenced unless the injury was not discoverable within this period. If it was not discoverable, the action may be commenced within *one year* from the date of discovery, but in no event may it be commenced more than *six years* after the date of the incident which is the basis of the action.²¹¹ This "tripartite standard"²¹² (1) requires an early filing (two years) if the injury is evident; (2) allows a very short period (one year) to accommodate those situations in which the injury was not discoverable in spite of the patient's good faith conduct; and (3) imposes an absolute maximum time limitation (six years).²¹³

This provision appears at first glance to accommodate the legitimate interests not only of health care providers but also of potential claimants, and for the great majority of patients it will no doubt prove to be reasonable and equitable. However, this provision may work a serious injustice in some cases. One such case involves fraudulent concealment:

When a physician knowingly prevents his patients from discovering the negligence within the prescribed period, the physician himself is responsible for the delay in bringing the claim. Thus, it seems neither fair nor logical to allow the doctor to contend under such circumstances that the claim is stale. . . . A statute of limitations should not be structured in such a way that it might be used to perpetrate a fraud.²¹⁴

It would seem appropriate, therefore, that the legislature adopt an exception by which the statute of limitations would not begin to run in the case of fraudulent concealment until such conduct was, or should have been by the exercise of due diligence, discovered.²¹⁵ The tremendous burden which the plaintiff bears in order to demonstrate affirmative fraud should adequately limit actions of this nature.²¹⁶

statute of limitations for malpractice action was based on substantial differences in circumstances for health care providers it was a reasonable classification; two year statute of limitations on actions for professional negligence was not unconstitutional as special legislation nor void for vagueness).

211. NEB. REV. STAT. § 44-2828 (Reissue 1978) (emphasis added).

212. Comment, *supra* note 25, at 1434.

213. This maximum limit will impose a hardship on some individuals, since it will bar meritorious claims in spite of the plaintiff's good faith efforts to file the claim as soon as reasonably possible. *See, e.g.*, Lincoln Journal, July 22, 1979, § B, at 1, col. 1. *But see* Comment, *supra* note 25, at 1434 n.79 (the unfairness to particular individuals who have their claims barred by absolute statutes of limitations "is outweighed by widespread societal benefit to be obtained by making the medical risk more easily insurable.").

214. Comment, *supra* note 25, at 1434-35. *See* note 200 & accompanying text *supra*.

215. *See, e.g.*, CAL. CIV. PROC. CODE, § 340.5 (West Supp. 1979).

216. Comment, *supra* note 25, at 1435 n.85. *See, e.g.*, Nardone v. Reynolds, 333 So. 2d 25 (Fla. 1976); Millett v. Dumais, 365 A.2d 1038 (Me. 1976); Sanchez v. Wade,

Another such case involves the situation in which the health care provider has left a foreign object in the patient's body.²¹⁷ The Nebraska statute of limitations provision may work an injustice. Since the foreign object would constitute direct evidence of negligence, the dangers of fraud, of evidence and witnesses that are no longer available, and of frivolous legislation are absent in this situation. A statutory exception similar to that suggested for fraudulent concealment is in order.

A reasonable statute of limitations is necessary so that the health care provider is not exposed to liability for his conduct for an extended period of time. However, by adding these exceptions, the interests of both the medical profession and the malpractice victim would be handled equitably. California, for instance, has enacted a statute which tolls the statute of limitations upon proof of fraud or the presence in the injured patient of a foreign object which has no therapeutic or diagnostic purpose, and similar exceptions are advisable for the Nebraska Act.²¹⁸

3. *Other Indirect Modifications*

a. *Limits on Attorney Fees*

The contingent fee system employed by most plaintiffs' attorneys is a source of bitter controversy.²¹⁹ Several states have enacted various means of constraining the attorneys' contingency fees.²²⁰ Some states fix a ceiling for the percentage recoverable as attorneys' fees in medical malpractice cases, *e.g.*, thirty-three and one third percent in Tennessee²²¹ and forty percent in Idaho.²²²

514 S.W.2d 812 (Tex. 1974). See generally W. PROSSER, *supra* note 12, § 18, at 105-08.

217. See W. PROSSER, *supra* note 12, § 39, at 227-28.

218. CAL. CIV. PROC. CODE, § 340.5 (West Supp. 1979). See also ARIZ. REV. STAT. § 12-564(B), (C) (Supp. 1957-1979); Tenn. Code Ann. § 23-3415(a) (Cum. Supp. 1979).

It may also be advisable to consider an exception for cases when an infant is injured through some type of medical negligence. If the injury is not readily detectable, but manifests itself in later years, the six year maximum limit could present a serious hardship. See Comment, *supra* note 1, at 674. Several states have enacted statutes to protect infants who are unable to detect their own injuries. See, *e.g.*, IND. CODE ANN. § 16-9.5-3-1 (Burns Cum. Supp. 1979) (two year statute of limitations except that a minor under the age of six has until his eighth birthday to file); OHIO REV. CODE ANN. § 2305.11(B) (Page Supp. 1978) (four year statute of limitations to file a malpractice action, however, "a minor who has not attained his tenth birthday shall have until his fourteenth birthday in which to file an action for malpractice . . .") See also 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 13.12; Redish, *supra* note 1, at 766.

219. See notes 23-33 & accompanying text *supra*.

220. See 2 LOUISELL & WILLIAMS, *supra* note 78, ¶ 20.07 n.60 (Cum. Supp. 1979).

221. TENN. CODE ANN. § 23-3419 (Cum. Supp. 1979). Under the Tennessee plan, the court may determine what fee shall be awarded an attorney who represents a

Other states adopt a sliding scale under which the amount of recovery determines the percentage the attorney will be paid.²²³ For instance, in New Jersey an attorney may receive up to fifty percent of the first \$1,000 recovered; forty percent of the next \$2,000; thirty-three and one third percent of the next \$50,000; and ten percent of any amount over \$100,000.²²⁴ Still other states, such as Nebraska, allow the court to determine whether the attorney's fees assessed are reasonable.

Nebraska's Act provides that "upon motion of either party the court shall review the attorney's fees *incurred by that party* and allow such compensation as the court shall deem reasonable."²²⁵ This approach, while repugnant to most plaintiff's attorneys, allows the court to determine on an individual basis, after analyzing the particular variables involved in the case, whether the attorney's charges are reasonable.²²⁶

Provisions regulating attorney's fees are subject to several criticisms. First, both plaintiff's and defendant's attorneys receive roughly proportionate wages, so such a provision serves little purpose as a regulatory device.²²⁷ This is because the "underlying intention in limiting contingency fees . . . , is to reduce the number of claims brought against health-care providers by minimizing the

medical malpractice claimant, but limits the maximum fee to one third of the recovery.

222. IDAHO CODE § 39-4213 (1977).

These provisions have several disadvantages. First, they will virtually eliminate valid, but small claims, since it will be economically unfeasible for attorneys to handle such cases. Conversely, unless the attorney contracts for less than the maximum amount, an attorney may receive an impropportionate share of the large verdicts, i.e., \$100,000 on a \$300,000 verdict if the state has a thirty-three and one-third flat percentage. This is true in spite of the amount of work involved. As one commentator note, "flat percentage ceilings are too crude a measure: they fail to provide sufficient compensation in some cases and fail to prevent excessive compensation in others." Comment, *supra* note 25, at 1445.

223. See Comment, *supra* note 25, at 1445-46.

224. R. GOVERNING CTS. OF N.J. 1: 21-7(C). This provision was found to be constitutional. See American Trial Lawyers Ass'n v. New Jersey Supreme Court, 126 N.J. Super. 577, 316 A.2d 19, *aff'd*, 66 N.J. 258, 330 A.2d 350 (1974). See also Note, *New Jersey's Maximum Contingent Fee Schedule: The Validity of the Rule 1:21-7*, 5 RUT.-CAM. L.J. 534 (1974). A graduated scale of contingent fees was recommended in the MALPRACTICE REPORT, *supra* note 1, at 34-35.

225. NEB. REV. STAT. § 44-2834(1) (Reissue 1978) (emphasis added). A patient also has the right to agree to pay his attorney for his services on a per diem basis if such agreement is exercised at the time of employment or by written agreement. Id. § 44-2834(3). The *Prendergast* court found that this provision establishing court review of attorneys fees was valid. 199 Neb. at 116-17, 256 N.W.2d at 669-70.

226. Comment, *supra* note 25, at 1444.

227. See text accompanying note 28 *supra*.

margin of profit for plaintiffs' attorneys and thereby diminishing their willingness to handle malpractice suits."²²⁸ However, this measure will not discourage attorneys from accepting plaintiffs' cases since the defendant is unable to request the court to review a plaintiff's attorneys fees. As long as the client is satisfied with the fees which the attorney has charged him, the opposing party has no recourse to the court.

Second, courts may abuse their discretion when reviewing attorney's fees when the court has no specific guidelines to follow. Arizona's statute,²²⁹ for instance, provides that when the court determines whether an attorney's fee is reasonable, it must consider the following specific factors:

1. The time and labor required, the novelty and difficulty of the questions involved and the skill requisite to perform the legal services properly.
2. The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
3. The fee customarily charged in the locality for similar legal services.
4. The amount involved and the results obtained.
5. The time limitations imposed by the client or by the circumstances.
6. The nature and length of the professional relationship with the client.
7. The experience, reputation and ability of the lawyer or lawyers performing the services.
8. Whether the fee is fixed or contingent.²³⁰

Guidelines similar to these insure uniformity in the review of attorneys fees.

Finally, it must be recognized that the contingency fee system currently eliminates small or questionable claims, since attorneys refuse to handle these claims, even if meritorious, because they are unprofitable.²³¹ If attorneys are unable to obtain fair compensation for their efforts due to court review of their fees, this may discourage them from accepting even more malpractice claims. The ultimate losers then may be the victim's of medical negligence since they might be unable to obtain qualified counsel.

*b. Informed Consent*²³²

A patient is entitled to know what will happen to his body and

228. Comment, *supra* note 1, at 671.

229. ARIZ. REV. STAT. § 12-568(A) (Supp. 1957-1979).

230. *Id.* These provisions were derived from ABA CODE OF PROFESSIONAL RESPONSIBILITY, CANONS, No. 2, DR 2-106(B)(1)-(8) (1978). See also F. MACKINNON, *supra* note 23; State *ex rel.* Nebraska Bar Ass'n v. Richards, 165 Neb. 80, 90, 84 N.W.2d 136, 143 (1957) (charging a "clearly excessive" fee is a ground for discipline).

231. MALPRACTICE REPORT, *supra* note 1, at 32-33.

232. There is an abundance of material written on this topic. Several of the more thorough analyses include 2 LOUISELL & WILLIAMS, *supra* note 78, ¶¶ 22.01-.09; Marks, *Informed Consent in Medical Malpractice Cases in Defense Research Institute, Defense of Medical Malpractice Cases*, 57 (D. Hirsh ed. 1977);

to participate actively in any decisions which will be made affecting it.²³³ He should be thoroughly informed of the anticipated beneficial results, the potential risks involved, and the consequences of foregoing treatment.²³⁴ In sum, the patient must have all the necessary information in order to make an intelligent and informed choice whether to proceed with treatment.²³⁵ This doctrine of informed consent is based on the belief that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . ."²³⁶

A health care provider who neglects to make adequate disclosures to a patient of the risks associated with a particular treatment may be held liable to the patient for consequent harm, regardless whether the health care provider has exercised the highest standard of care.²³⁷ The difficulty with this doctrine is that the existence or nonexistence of the informed consent has been determined entirely on a case-by-case basis. Because all the decisions are unique, they are uncertain guides to future conduct.²³⁸ This in turn has led to additional, often unnecessary, litigation to determine whether the patient's consent was informed.²³⁹ Genuine misunderstandings arise because health care providers may believe they have thoroughly explained the treatment and its possible ramifications to the patient, but the patient may not have understood much of what was said, or his expectations may have been so high that he disregarded the health care provider's warnings.²⁴⁰ Moreover, health care providers face a dilemma in many cases since disclosing all possible risks involved might frighten the patient, perhaps doing more harm than good, or perhaps even resulting in the patient "refusing treatment even where the potential benefit would far outweigh the risk."²⁴¹

Shartsis, *Informed Consent: Some Problems Revisited*, 51 NEB. L. REV. 527 (1972); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Annot., 79 A.L.R.2d 1028 (1961) (physician's duty to inform patient of the nature and hazards of disease or treatment); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970). See also *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

233. MALPRACTICE REPORT, *supra* note 1, at 74.

234. *Id.*

235. *Id.*

236. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *rev'd*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E. 3 (1957).

237. Comment, *supra* note 25, at 1436-37.

238. *Id.* at 1437.

239. *Id.*

240. MALPRACTICE REPORT, *supra* note 1, at 75.

241. *Id.* The reason for this is that patients are often apprehensive about potential treatment. In those cases where there is a genuine concern that the benefits of informing the patient will be outweighed by the anxiety which this creates

The Nebraska Act provides that "[i]nformed consent shall mean consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities."²⁴² The problem with a measure such as this is that it places the patient's right to be informed entirely within the discretion of the medical profession, without any inquiry into the importance the undisclosed information would have for the patient. It also requires a plaintiff to use expert testimony to prove²⁴³ nondisclosure of pertinent information, and such testimony is often difficult to obtain.²⁴⁴

In order to avoid further confusion, the legislature should define more precisely what factors the health care provider must disclose to the patient in order to allow the health care provider to rest assured that the patient's consent is truly informed. For instance, six factors have been suggested which are appropriate for disclosure where circumstances permit: (1) the diagnosis; (2) the general nature of the contemplated procedure; (3) the risks involved; (4) the prospects of success, (5) the prognosis if the proce-

in the patient, a close relative or friend should be fully informed. *Id.* See Comment, *supra* note 24, at 1439-40. See also 2 LOUISELL & WILLIAMS, *supra* note 78, ¶ 22.02 ("The Emotionally Unstable or Unduly Apprehensive Patient").

242. NEB. REV. STAT. § 44-2816 (Reissue 1978). See also *Canterbury v. Spence*, 464 F.2d 772, 787-88 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (the relevant topics which the physician must communicate to the patient are "the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely, if the patient remains untreated"); 2 LOUISELL & WILLIAMS, *supra* note 78, ¶ 22.03 ("Community Standards as to Disclosure").

243. Regarding the burden of proof in informed consent cases, the Nebraska Act provides that

[b]efore the plaintiff may recover any damages in any action based on failure to obtain informed consent, it shall be established by a *preponderance of the evidence* that a reasonably prudent person in the plaintiff's position would not have undergone the treatment had he been properly informed and that the lack of informed consent was the *proximate cause* of the injury and damages claimed.

NEB. REV. STAT. § 44-2820(2) (Reissue 1978) (emphasis added).

244. See note 345 *infra*. The general rule in jurisdictions using the locality test seems to be that "the patient must prove standards of disclosure among reasonable medical practitioners in the same or similar circumstances by adducing expert testimony, as well as facts showing that defendant's disclosures did not accord with such community standards." 2 LOUISELL & WILLIAMS, *supra* note 78, ¶ 22.03, at 594.48. *Accord*, *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971). *Contra*, *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969); *Cooper v. Roberts*, 220 Pa. Super. Ct. 260, 286 A.2d 647 (1971); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972). See also Note, *A New Standard of Informed Consent in Medical Malpractice Cases—The Role of the Expert Witnesses*, 18 St. Louis U. L.J. 256 (1973).

ture is not performed; and, (6) alternate methods of treatment, if any.²⁴⁵ If this disclosure is to be meaningful, it is also essential that it is made in terms which the patient can understand, and any legal implications of the consent must be made known before the patient signs.²⁴⁶ The statute might provide for a written consent form incorporating these provisions.²⁴⁷ When the patient signs the form, after having had an opportunity to read it and ask questions, a rebuttable presumption arises that the consent was based on adequate disclosure.²⁴⁸ Such a provision would have the added advantage of uniformity.²⁴⁹

Health care providers contend that such detailed disclosures are seldom possible²⁵⁰ and certainly there are circumstances where the health care provider should be under no duty to disclose.²⁵¹ But a more precise scheme of disclosure balances both the interests of health care providers and patients, and provides

245. 2 LOUISELL & WILLIAMS, *supra* note 78, ¶ 22.01, at 594.43-44. *See also* Note, *supra* note 232, at 1561 (listing nine factors that should be disclosed to the patient).

246. *See* Comment, *supra* note 25, at 1438.

247. *See, e.g.*, FLA. STAT. ANN. § 768.46 (West Cum. Supp. 1979); IOWA CODE ANN. § 147.137 (West Cum. Supp. 1979-1980); OHIO REV. CODE ANN. § 2317.54 (Page Supp. 1978). *See also* MALPRACTICE LIFELINE, Apr. 30, 1979, at 6-7. The Texas legislature has taken a detailed "spell-it-out" approach to informed consent. The Texas Medical Disclosure Panel, comprised of six physicians and three attorneys, was created to delineate long lists of medical and surgical procedures and then to outline the specific risks with each that must be disclosed to patients. This information is given in writing to the patient and signed in the presence of a witness. This creates a rebuttable presumption that the physician has given sufficient information to the patient of potential risks. It is hoped that such an approach will eliminate the physicians' uncertainty about what they must and must not reveal to the patients. TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.01-.07 (Vernon Cum. Supp. 1980); Comment, *Medical Liability and Insurance Improvement Act of Texas: The New Legislative Procedure for Amputation of Patient's Rights*, 30 BAYLOR L. REV. 481, 494-501 (1978).

248. Comment, *supra* note 1, at 676. The communication between the health care provider and patient which is necessary to satisfy these written consent forms may also improve the physician-patient relationship in general. *See id.* *See also* notes 77-87 & accompanying text *supra*.

249. *See* MALPRACTICE REPORT, *supra* note 1, at 74-75. *But cf.* MALPRACTICE DIG. Jan./Feb. 1979, at 2 ("Many of the written consent forms currently utilized will not stand up to judicial scrutiny. No form will eliminate all possibility of an action or guarantee a favorable outcome if suit is instituted.").

250. 2 LOUISELL & WILLIAMS, *supra* note 78, ¶ 22.01, at 594.44. Health care providers argue that most procedures are exceptionally complex and virtually impossible to explain to lay persons. They also claim that disclosing all the details creates unnecessary anxiety, and that there are an infinite number of possible adverse results, none of which are necessarily probable, so health care providers are unable to determine precisely when to stop disclosing. *Id.*

251. There are a number of current exceptions in which the health care provider is under no duty to disclose, including certain emergency treatments, common

clearer guidance for future conduct. Regardless which approach the legislature takes, more thoughtful drafting is needed in this area to eliminate the present uncertainty both health care providers and patients experience.

c. Written Guarantees

Although oral warranties are only infrequently relied on as the basis of a malpractice suit,²⁵² the Nebraska Act provides that "[n]o liability shall be imposed upon any health care provider on the basis of an alleged breach of an express or implied contract assuring results . . . , unless such contract is expressly set forth in writing"²⁵³ Consequently, any guarantees or assurances of successful treatment are unenforceable unless they are committed to writing. This provision is intended to allow health care providers to be reasonably optimistic without incurring potential liability for breaching an implied warranty contract.²⁵⁴ It also prohibits the court from implying a contractual warranty without concrete evidence.²⁵⁵ Requiring assurances of results to be in writing may eliminate much of the uncertainty caused by alleged oral guarantees, and may encourage health care providers to make reasonable therapeutic assurances to the patient. This would facilitate better communications, and consequently better relations between the health care provider and the patient. In addition, since poor communications is a significant contributing factor in the malpractice crisis,²⁵⁶ this psychological support may play an important role in reducing malpractice suits.²⁵⁷ The contrary may also be true, however, *i.e.*, health care providers may be less cautious in making oral guarantees, realizing that their liability is limited to whatever as-

knowledge, unknown risk, waiver and "therapeutic exceptions." See Comment, *supra* note 24, at 1439-40. See generally W. PROSSER, *supra* note 12, § 18.

252. Comment, *supra* note 1, at 676. From the plaintiff's standpoint there are two distinct advantages of pleading the malpractice case as one of breach of contract: "[B]reach of contract is generally easier to prove than negligence and contract actions are subject to longer statutes of limitations." Comment, *supra* note 24, at 1450. See MALPRACTICE REPORT, *supra* note 1, at 30; But see note 199 & accompanying text *supra*. See generally Note, *Express Contracts to Cure: The Nature of Contractual Malpractice*, 50 IND. L.J. 361 (1975); 41 TENN. L. REV. 964, 966 (1974).

253. NEB. REV. STAT. § 44-2818 (Reissue 1978). See also FLA. STAT. ANN. § 725.01 (West Cum. Supp. 1979); IND. CODE ANN. § 16-9.5-1-4 (Burns Cum. Supp. 1979); OHIO REV. CODE ANN. § 1335.05 (Page 1979); UTAH CODE ANN. § 78-14-6 (1953).

254. Comment, *supra* note 1, at 676.

255. *Id.*

256. See notes 77-87 & accompanying text *supra*.

257. However, allowing only written contracts of assurance may also eliminate a meritorious claim based on a legitimate assurance by the health care provider which is not in writing. Comment, *supra* note 25, at 1451.

surances are expressly set forth in writing. The ultimate success of this provision may be based on two tenuous premises: (1) that patients are aware that any assurances or guarantees from the health care provider must be in writing, and (2) that the patient will insist that these assurances are included in a written guarantee. It seems unlikely that most patients would be aware of either of these elements. Consequently, patients who reasonably rely on health care providers' oral assurances may be deprived of a remedy simply because they were unaware that such promises must be in writing or were unwilling to demand a written guarantee.

d. Standard of Care

Traditionally, a health care provider was required to meet the standard of performance generally adhered to in the community or locality where he practiced, *i.e.*, the health care provider was required to exercise the reasonable care and skill expected of a health care provider living in that geographic area.²⁵⁸ There was a tendency by the judicial branch, however, to expand the standard of care in order to hold health care providers to a higher standard, the standard of care in similar communities.²⁵⁹ Proponents argued that what was necessary was a uniform nationwide standard of care²⁶⁰ based on the most progressive medical techniques available, and this is precisely the direction in which many courts were headed.²⁶¹ The injured party could more readily establish negligent conduct since the alleged conspiracy of silence no longer

258. Comment, *supra* note 1, at 674. See A. HOLDER, *MEDICAL MALPRACTICE LAW* 43-53 (2d ed. 1978); 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 8.06; Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969); Comment, *Medical Malpractice—The "Locality Rule" and the "Conspiracy of Silence"*, 22 S.C. L. REV. 810 (1970). See generally W. PROSSER, *supra* note 12, § 30; Annot., 37 A.L.R.3d 420 (1971); Annot., 36 A.L.R.3d 440 (1971).

259. Comment, *Legislative Responses to the Medical Malpractice Crisis*, 39 OHIO ST. L.J. 855, 866 (1978).

260. 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 8.06, at 211.

261. See, e.g., *Murphy v. Little*, 112 Ga. App. 517, 145 S.E.2d 760 (1965); *Griego v. Grieco*, 90 N.M. 174, 561 P.2d 36 (1977); *Hirschberg v. State*, 91 Misc. 2d 590, 398 N.Y.S.2d 470 (1977); *Cavallaro v. Sharp*, 84 R.I. 67, 121 A.2d 669 (1956); *Hundley v. Martinez*, 151 W. Va. 1013, 158 S.E.2d 159 (1967). But see *Correia v. United States*, 339 F.2d 596 (1st Cir. 1964); *Bullard v. North Carolina Nat'l Bank*, 31 N.C. App. 312, 229 S.E.2d 245 (1976); *Meeks v. Marx*, 15 Wash. App. 571, 550 P.2d 1158 (1976). The Nebraska courts, however, have generally adhered to the locality standard of care. See, e.g., *Anderson v. Moore*, 202 Neb. 452, 275 N.W.2d 842 (1979); *Kortus v. Jensen*, 195 Neb. 261, 237 N.W.2d 845 (1976); *Mecham v. McLeay*, 193 Neb. 457, 227 N.W.2d 829 (1975); *Halligan v. Cotton*, 193 Neb. 331, 227 N.W.2d 10 (1975); *Bailey v. Williams*, 189 Neb. 484, 203 N.W.2d 454 (1973); *Meyer v. Moell*, 186 Neb. 397, 183 N.W.2d 480 (1971).

presented a significant obstacle,²⁶² and the patient was not limited to a specific geographic area in selecting his expert witness.

In an effort to shield health care providers from the increased liability which resulted from this broad standard, the Nebraska Act adopted the locality rule for medical malpractice cases:

Malpractice or professional negligence shall mean that, in rendering professional services, a health care provider has *failed to use the ordinary and reasonable care, skill, and knowledge ordinarily possessed and used under like circumstances by members of his profession engaged in a similar practice in his or in similar localities*. In determining what constitutes reasonable and ordinary care, skill, and diligence on the part of a health care provider in a particular community, the test shall be that which health care providers, in the *same community or in similar communities and engaged in the same or similar lines of work*, would ordinarily exercise and devote to the benefit of their patients under like circumstances.²⁶³

Although this locality rule may reduce the number of successful malpractice suits and create a favorable environment for the insurance industry, it may also permit the standard of care in a particular community (especially a rural community) to lag substantially behind modern medical advancements.²⁶⁴ In light of the "improved educational opportunities and communication there is little justification for a small town doctor to be less expert than a metropolitan area doctor claiming the same degree of specialization."²⁶⁵ At the very least, if the health care provider practices in an area which lacks the best facilities or latest techniques, he should be required to advise his patients and allow them to decide whether to pursue treatment elsewhere.²⁶⁶ In sum, holding health care providers to the standard of care in the community may reduce the number of instances where the plaintiff can establish that the health care provider was negligent if the community has a lower standard, but it may do so at the expense of medical proficiency and fundamental fairness to the patient.

B. Pre-Trial Review Panel²⁶⁷

A pre-trial review panel is an alternative adjudicatory device

262. Comment, *supra* note 1, at 675. It may, however, present an even greater financial burden to the patient who is required to pay travel expenses for experts traveling long distances.

263. NEB. REV. STAT. § 44-2810 (Reissue 1978) (emphasis added).

264. Comment, *supra* note 1, at 678.

265. Comment, *supra* note 259, at 867 (footnote omitted).

266. 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 8.06, at 212.

267. There are three primary differences in these panels: 1) *Mandatory v. Voluntary*: whether the malpractice claim must go to the pretrial panel stage before being litigated or whether it proceeds directly to trial unless a party requests a panel hearing, 2) *Pre-Complaint v. Post-Complaint Review*: whether the panel hears the complaint prior to formal initiation of litigation (the majority of panels are pre-complaint), and, 3) *Influence of the Panel*: the

which facilitates the resolution of malpractice disputes.²⁶⁸ While damage limits are a legislative effort to confront the problems after the malpractice is established, review panels attempt to confront the problem at the outset of the claim. Unlike an arbitrator's decision, the conclusions of these panels are typically not binding on the parties, so a party who is dissatisfied with the panel's determination may proceed to trial.²⁶⁹ These panels evolved from a general dissatisfaction with traditional trial procedures. Proponents of pre-trial review panels argued that traditional litigation procedures were lengthy, time consuming and expensive.²⁷⁰ Moreover, they felt that inexperienced decision makers (jurors, attorneys and claims administrators) were making erroneous decisions and granting excessive awards.²⁷¹

Pre-trial review panels were seen as a viable alternative to the traditional trial which could quickly and inexpensively screen out meritless claims while settling disputes in an equitable fashion.²⁷² Moreover, it was believed that since this procedure was informal and private, with objective, qualified individuals making the determination, many claims would be resolved at this initial stage.²⁷³ Parties would be better equipped and under greater pressure to negotiate settlements since the merits of their cases would become apparent during the panel hearings. The alternative advantage to plaintiffs was that these panels would operate as discovery devices,²⁷⁴ and plaintiffs would be entitled to subpoena the panel

degree of influence which the panel's decision will have on the final outcome. ABA REPORT, *supra* note 1, at 43. For an excellent analysis of medical-legal screening panels, see Documentary Supplement, *supra* note 57. For an extensive comparative analysis of the various alternative means of dispute resolution in malpractice cases, see Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 214 (Appendix).

268. ABA REPORT, *supra* note 1, at 41.

269. See Comment, *supra* note 1, at 682. See generally Comment, *supra* note 24, at 1463-67; Virginia Legal Research Group, *Alternatives to Litigation, IV: The Law of Arbitration in the U.S.*, reprinted in MALPRACTICE REPORT, *supra* note 1, at 346 (Appendix).

270. See ABA REPORT, *supra* note 1, at 44. See also notes 57-60 & accompanying text *supra*. Additional problems with a traditional trial in the malpractice context are long delays between filing and disposition, which increases costs; difficulties in obtaining qualified expert witnesses to testify; increased costs in preparing the case, nuisance suits; and complexity of subject matter. Comment, *supra* note 161, at 1186-87. The majority of problems typically attributed to the present fault-liability approach to resolving medical malpractice claims are outlined in Note, *supra* note 90, at 96-97.

271. ABA REPORT, *supra* note 1, at 44-45.

272. *Id.* at 45.

273. *Id.*

274. *Id.* However, some individuals objected to these panels for precisely this reason, fearing that the opposing counsel would abuse these discovery devices

members to appear at the subsequent trial,²⁷⁵ thus avoiding the "conspiracy of silence."²⁷⁶ Finally, it was believed that such procedures would significantly reduce the burden on the courts.²⁷⁷

Prior to 1975, only New Hampshire had provided for pre-trial review by statute, although New Jersey had a similar procedure by court rule. Since 1975, twenty-seven states, including Nebraska, have adopted some form of statutory pre-trial review panel, while eleven other states had some form of binding or non-binding arbitration panel.²⁷⁸

Although Nebraska's pre-trial review panel bears similarities to many of these panels, it is more comprehensive than most. Under the Nebraska Act,²⁷⁹ before an individual may commence a malpractice claim against a health care provider in any court in the state, the claim must be presented to a medical review panel.²⁸⁰ This panel is composed of three licensed physicians and one attorney, who has no vote, but who acts in an advisory capacity as chairman of the panel.²⁸¹ In addition, the Director of Insurance appoints a physician from the members of the Board of Examiners of Medicine and Surgery to observe and advise the panel.²⁸² The panel is selected from a pool of all the licensed physicians actively practicing in the state.²⁸³ Each party to the action selects one physician, and these two physicians select a third physician to serve on the panel.²⁸⁴ Once these panelists are selected, they are required to serve unless they are excused by the court for good

to build a much stronger case on his opponents efforts. See Comment, ARIZ. ST. L.J., *supra* note 165, at 179; Note, *Ohio's Rx for the Medical Malpractice Crisis: The Patient Pays*, 45 U. CIN. L. REV. 90, 101-02 (1976).

275. See, e.g., NEB. REV. STAT. § 44-2844(2) (Reissue 1978).

276. See note 345 *infra*.

277. ABA REPORT, *supra* note 1, at 45.

278. *Id.* at 41-42.

279. NEB. REV. STAT. §§ 44-2840 to -2847 (Reissue 1978).

280. *Id.* § 44-2840(2). These provisions apply to *all* malpractice claims, *id.* § 2840(1), unless the health care provider does not qualify under the act or the patient elects not to be covered. *Id.* § 44-2821(1), (2). The proceedings before the panel are initiated when the patient or his representative delivers (or mails by certified or registered letter) a copy of the complaint upon the Director of Insurance personally. *Id.* § 44-2840(3). This notice must indicate the plaintiff's choice of physician and attorney and the court where any necessary action will be filed. *Id.*

281. *Id.* § 44-2841(1).

282. *Id.* § 44-2847(2). The purpose of this observer is to insure uniformity in these procedures, but alternative means of insuring uniformity are also advisable. See, e.g., note 300 *infra*.

283. *Id.* § 44-2841(2)(a).

284. *Id.* § 44-2841(2)(b). If one of the health care providers involved is a hospital, the hospital must select a fourth panelist who is a hospital administrator. *Id.* If multiple parties are involved, the plaintiffs and defendants select only one physician each. *Id.* § 44-2841(2)(c).

cause, *i.e.*, facts demonstrating that service on the panel would constitute an "unreasonable burden or undue hardship."²⁸⁵ Each party may twice challenge without cause a selection by the opposing party.²⁸⁶ If both challenges are exercised, the judge then submits a list comprised of three qualified panelists, each party is allowed to strike one name from this list, leaving the finalist to "serve in place of the challenged panelist designated by the party"²⁸⁷ A similar procedure is used if the parties are unable to agree on an attorney to serve on the board.²⁸⁸

Several initial problems are presented by this provision. Although the selection process may be objective, it could result in an attorney with no expertise in malpractice litigation advising the physicians on the panel. Different legal standards may consequently be applied in determining whether there is a material issue of fact, and whether there is a sufficient case for submission to the court or jury.²⁸⁹ The absence of attorneys who are qualified to handle malpractice cases reduces the potential effectiveness of the panel.²⁹⁰ Moreover, in cases involving multiple parties, it seems inevitable that disagreements among the parties will arise over which physician should serve on the panel.²⁹¹ This will be particularly true when several specialists are defendants, and such disagreements may result in additional delays and expenses.

After the panel is selected, the parties submit their evidence in written form only.²⁹² If a party fails to submit his evidence in a reasonable time, the panel may make a determination based on whatever evidence has been submitted.²⁹³ The parties may submit medical charts, x-rays, laboratory test results, excerpts of treatises, depositions of witnesses and parties, or any other written form

285. *Id.* § 44-2841(2)(d). The panelists are compensated only \$30 a day for all work performed as a member of the panel. *Id.* § 44-2845. At first glance this would not appear to encourage participation, but it may represent a small sacrifice to pay for reduced premiums. *See also* FLA. STAT. ANN. § 768.44(i) (West Cum. Supp. 1979) (each non-judicial panelist is paid \$100 per day for expenses).

286. NEB. REV. STAT. § 44-2841(2)(f) (Reissue 1978).

287. *Id.*

288. *Id.* § 44-2841(2)(g).

289. Mallor, *supra* note 32, at 113.

290. *Id.* Alternatively, since the court supplies the list of qualified attorneys this may result in a small group of attorneys being required to serve numerous times.

291. One study indicated that 44% of the claims presented involved multiple defendants. *See* NAIC STUDY, *supra* note 65, at 53 (table 11).

292. NEB. REV. STAT. § 44-2842(1). This is consistent with the purpose of maintaining an informal proceeding without cross examinations and lengthy oral presentations. *See* notes 334-37 & accompanying text *infra*.

293. NEB. REV. STAT. § 44-2842(1) (Reissue 1978). The panel determines what a reasonable time is. *Id.*

which the panel allows.²⁹⁴ Moreover, the panel has the duty to request all the necessary information, consult with medical authorities and examine all the necessary reports in order to inform fully itself regarding the issue to be decided.²⁹⁵ Both parties have full access to any material submitted to the panel.²⁹⁶

When all the evidence has been submitted, either party, after giving ten days notice to the other party, may convene the panel at a time and place agreeable to the panel members.²⁹⁷ Either party may present "argument concerning any matters relevant to issues to be decided by the panel before the issuance of its report."²⁹⁸ All proceedings before the panel, all actions taken by the parties in preparing for the proceedings and all matters submitted to the panel are confidential.²⁹⁹ The hearings are conducted in private and are not matters of public record.³⁰⁰

After reviewing all the evidence the panel must, within thirty days, express its opinion in writing as to whether the evidence supports the conclusion that the defendant neglected to act within the applicable standard of care.³⁰¹ The panel is free to return one of three decisions:

(a) The evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint in specified particulars;

(b) The evidence supports the conclusion that the defendant involved met the applicable standard of care required under the circumstances; or

(c) There is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury in specified particu-

294. *Id.* The depositions of parties and witnesses may be taken prior to convening of the panel if the attorney of the health care provider is furnished a copy of the petition which the claimant intends to file 10 days before the deposition is taken. *Id.* § 44-2842(2). Moreover, the patient is entitled to receive all the medical and hospital records relating to the case which are admissible in evidence in a court of law. *Id.*

295. *Id.* § 44-2843(1).

296. *Id.*

297. *Id.* § 44-2842(3).

298. *Id.* This provision is unclear in that the parties may elect to present extensive argument. This may present a problem of expediency. A possible suggestion would be to limit the argument to what the panel deems reasonable.

299. *Id.* § 44-2846(1).

300. *Id.* Although these privacy provisions are worthwhile from the patient's point of view, they also "operate to impede predictability and uniformity of decision." Comment, *supra* note 25, at 1463. If the panel decisions and reasoning were made public, this would encourage settlements by forecasting how particular cases have been addressed in the past. *Id.* In order to protect the party's identity, the panel's decision could be published without the party's name. *Id.* This type of data collection would be extremely beneficial in reducing nonmeritorious claims, since it would indicate how similar claims had been resolved in the past.

301. *Id.* § 44-2843(2).

lars.³⁰²

The panel is to concern itself only with these issues, and they are not to consider or report on disputed questions of law.³⁰³ Nor does the panel estimate the dollar amount of damages or the percentage of disability.³⁰⁴ A majority vote of the panel members controls.³⁰⁵

The claimant may subsequently request a review by filing his request and a copy of the alleged complaint with the Director of Insurance.³⁰⁶ The report of the panel is admissible in evidence at trial, but the report is not conclusive and either party may call any

302. *Id.* § 44-2843(3)(a)-(c).

303. *Id.* § 44-2847(1).

304. *Id.* § 44-2843(4). There appear to be several reasons for excluding damage provisions, one of which is based on the same objection which applies to *ad damnum* clauses, *i.e.*, they are not a true approximation of what a plaintiff actually expects to recovery. See notes 183-94 & accompanying text *supra*. Additionally, estimating damages can involve tedious and difficult issues which would proportionately reduce the panel's efficiency. Even if the panel were to assume such a function, it is questionable whether the voting members (physicians) would be adequately trained in this field.

Some states, while prohibiting their panels from determining damages, allow the panels to draw limited findings as to liability. For instance, in Indiana the panel may also decide that "[t]he conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered: (1) any disability and the extent and duration of the disability, and, (2) any permanent impairment and the percentage of the impairment." IND. CODE ANN. § 16-9.5-9-7 (Burns Cum. Supp. 1979). A detailed finding of liability would be within the scope of the panel's actions and would not seem to unnecessarily delay the process. Furthermore, this additional determination would assist the counsel in evaluating the strengths and weaknesses of their cases, thus enhancing the possibility for settlement. See Comment, *supra* note 25, at 1460. Other statutes provide that the panel shall determine the amount of damages. See, *e.g.*, ARK. STAT. ANN. § 34-2605 (Cum. Supp. 1979); ILL. ANN. STAT. ch. 110, § 58.7(1) (Smith-Hurd Cum. Supp. 1979).

305. NEB. REV. STAT. § 44-2843(4) (Reissue 1978).

306. *Id.* § 44-2844(1). Arizona enacted legislation which required that if the review panel's finding was favorable to the defendant, the plaintiff had to post a \$2,000 bond payable to the defendants for the assessed costs and fees in the event he did not prevail at trial, and the action was dismissed if the bond was not posted. Similarly, if the panel found for the plaintiff, the defendant had to post a \$2,000 bond or suffer a default judgment. ARIZ. REV. STAT. ANN. § 12-567(I), (J) (Supp. 1957-1979). These provisions were declared unconstitutional, however, in *Eastin v. Broomfield*, 116 Ariz. 576, 570 P.2d 744 (1977) (violations of privilege and immunities clause of the state constitution). See Comment, ARIZ. ST. L.J., *supra* note 165, at 188-90. But see MASS. GEN. LAWS ANN. ch. 231, § 60B (West Cum. Supp. 1979) (*only* plaintiff is required to file a \$2,000 cost bond if the review panel finds for the defendant and the court may increase this amount at its discretion; the action is dismissed if the bond is not posted within 30 days; if the plaintiff is indigent, the court may reduce, but not eliminate the amount of the bond). This provision was held to be constitutional in *Paro v. Longwood Hosp.*, 369 N.E.2d 985 (Mass. 1977).

member of the review panel as a witness.³⁰⁷ If called, the panel members are required to appear and testify, but they are absolutely immune from civil liability "for all communications, findings, opinions and conclusions made in the course and scope of [their] duties"³⁰⁸

In *Prendergast v. Nelson*,³⁰⁹ the Nebraska Supreme Court rejected all of the plaintiff's constitutional challenges to the medical review panel provisions of the Nebraska Act, though some of these objections had been accepted by courts in other jurisdictions hearing analogous cases.³¹⁰

The defendant argued first, that requiring individuals to submit their claims to a panel prior to initiating an action in court violated a provision of the Nebraska Constitution which provides: "All courts shall be open, and every person, for any injury done him in his lands, goods, person or reputation, shall have a remedy by due course of law, and justice administered without denial or delay."³¹¹ The court concluded that this constitutional provision was merely a general declaration of rights and remedies, and that the legislature was vested with the power to impose a special procedure before resorting to the courts.³¹² The defendant was not denied access to the courts since the panel's limited finding was not binding and he was free to proceed to the courts for a final determination.³¹³

Second, the defendant argued that this procedure deprived him of his right to jury trial in violation of the state³¹⁴ and federal con-

307. NEB. REV. STAT. § 44-2844(2) (Reissue 1978). Any minority reports of the panel are also admissible. *Id.*

308. *Id.* § 44-2844(3).

309. 199 Neb. 97, 256 N.W.2d 657 (1977).

310. See, e.g., *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976). But see *Eastin v. Broomfield*, 116 Ariz. 576, 570 P.2d 744 (1977); *Carter v. Sparkman*, 355 So. 2d 802 (Fla. 1976), *cert. denied*, 429 U.S. 1041 (1977); *Jones v. State Bd. of Med.*, 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914 (1977); *Everett v. Goldman*, 359 So. 2d 1256 (La. 1978); *Paro v. Longwood Hosp.*, 369 N.E.2d 985 (Mass. 1977); *Comiskey v. Arlen*, 55 App. Div. 2d 304, 390 N.Y.S.2d 122 (1976), *aff'd*, 43 N.Y.2d 696, 372 N.E.2d 34, 401 N.Y.S.2d 200 (1977); *Halpern v. Gozan*, 85 Misc. 2d 753, 381 N.Y.S.2d 744 (Sup. Ct. 1976); *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978).

311. NEB. CONST. art. I, § 13.

312. 199 Neb. at 103, 256 N.W.2d at 663.

313. *Id.* at 105, 256 N.W.2d at 664. It is important to note that when a party requests a review, the statute of limitations is tolled for 90 days after the opinion of the panel is rendered. See NEB. REV. STAT. § 44-2844(1) (Reissue 1978).

314. NEB. CONST. art. I, § 6 ("The right of trial by jury shall remain inviolate").

stitutions.³¹⁵ But the court again rejected the defendant's contentions because the jury, not the panel, is the ultimate arbitrator of all factual issues presented.³¹⁶ This procedure merely furnishes expert testimony for consideration in subsequent court actions. Even if an adverse panel finding might unduly influence the jury at the trial, the court felt that this would be a "two-way street which equally affects the parties on both sides."³¹⁷ In fact, the court believed that juries generally would be able to evaluate the panel's finding objectively.³¹⁸

Third, the defendant argued that the review panel restricted the court's jurisdiction in violation of the state constitution.³¹⁹ The court rejected this theory, however, because the Nebraska Act is elective; the panel provides no more than an expert opinion and has no authority to resolve finally the action; this procedure constitutes no more than a pretrial settlement conference which in "no way encroaches on the powers or prerogatives of the court."³²⁰

Finally, the defendant contended that the review panel provision denied citizens equal protection and due process of law since the Nebraska Act singles out a class of people (health care providers) for special treatment, but bears no rational relationship to the legitimate purposes of the legislation.³²¹ After analyzing the complex issues in the medical field which the Act was intended to remedy, the court concluded that the classification was rational, constitutional, and free from invidious discrimination.³²² The legislature had the right to exercise its police power to implement the Act in order to promote the general health and welfare of the citizens of the state.

Several significant features of the Nebraska Act indicate that it may be effective. Most significant is the fact that appearance before the panel is mandatory.³²³ Any malpractice action which is

315. U.S. CONST. amend. VII ("In Suits at common law . . . the right of trial by jury shall be preserved . . .").

316. 199 Neb. at 106-09, 256 N.W.2d at 665-66.

317. *Id.* at 109, 256 N.W.2d at 666.

318. Quoting *Halpern v. Gozan*, 85 Misc. 2d 753, 759, 381 N.Y.S.2d 744, 748 (Sup. Ct. 1976), the court concluded: "Historically, jurors for the most part have proven their independence. They guard their roles with a unique jealousy." 199 Neb. at 109-10, 256 N.W.2d at 666.

319. NEB. CONST. art. V, § 9.

320. 199 Neb. at 110, 256 N.W.2d at 667.

321. *Id.* at 110-12, 256 N.W.2d at 667. See note 156 *supra*.

322. 199 Neb. at 113, 256 N.W.2d at 668.

323. "No action against a health care provider may be commenced . . . before the claimant's proposed petition has been presented to a medical review panel . . ." NEB. REV. STAT. § 44-2840(2) (Reissue 1978) (emphasis added). However, the patient can elect not to be covered by the Act, in which case the rules of common law would seem to apply, although this is not clear from the

not initially submitted to the review panel should be dismissed since this step is a mandatory condition precedent.³²⁴ Several legislatures have implemented screening panels but have made their use optional or voluntary,³²⁵ which diminishes much of their effectiveness.³²⁶ This is because parties often elect to forego utilizing the panel, for one of a number of reasons: the plaintiffs may question the objectivity of a panel composed primarily of physicians;³²⁷ defense attorneys may perceive these panels as no more than extensive discovery devices, and they are reluctant to provide the patients with any additional information;³²⁸ or the parties may simply distrust the panels generally, preferring to have their case heard by a jury comprising a cross section of the community.³²⁹ In light of these objections, it does not appear that voluntary review panels are frequently used by the parties nor are they effective.³³⁰ This conclusion was supported by a study comparing the screening panels in New Mexico, New York, New Jersey and Pennsylvania³³¹ which found that appearances before these review panels must be

Act. *Id.* § 44-2821(2). This common law application appears to be probable, since a health care provider who fails to qualify under the Act is subject to common law doctrines. *Id.* § 44-2821(1). However, the decision not to be bound by the Act may jeopardize one's ability to receive health care. See note 157 *supra*.

324. See, e.g., *Walt Disney World Co. v. Memorial Hosp.*, 363 So. 2d 598 (Fla. Dist. Ct. App. 1978) (plaintiff's malpractice claim dismissed because there was no evidence it had been first submitted to medical mediation panel); *Riccobono v. Cordis Corp.*, 341 So. 2d 805 (Fla. Dist. Ct. App. 1977) (same); *Mount Sinai Hosp., Inc. v. Wolfson*, 327 So. 2d 883 (Fla. Dist. Ct. App. 1976) (same); *Knepper v. State*, 359 So. 2d 1127 (La. App. 1978) (same); *Vincent v. Voorhies*, 359 So. 2d 1129 (La. App. 1978) (same; dismissed without prejudice).

325. Comment, *supra* note 25, at 1458. The majority of the statutes require all medical malpractice claims to be presented to the panel prior to initiating any court action. ABA REPORT, *supra* note 1, at 43.

There are several general types of voluntary procedures: (1) those which are voluntarily invoked by the patient, which the health care provider must participate in, see, e.g., ARK. STAT. ANN. § 34-2603 (Cum. Supp. 1979); (2) those which are voluntarily invoked by either party with the non-invoking party being forced to go through the procedure, see, e.g., VA. CODE ANN., *Med. Malp. Rules of Practice*, Rule 2(C) (Cum. Supp. 1979); and (3) those which are voluntary on the part of the court, in which the court decides whether an expert advisory opinion is needed, and both parties are required to go through the procedure, see, e.g., KAN. STAT. ANN. § 65-4901 (Cum. Supp. 1979).

326. Documentary Supplement, *supra* note 57, at 715-17; Comment, *supra* note 25, at 1458.

327. ABA REPORT, *supra* note 1, at 47.

328. *Id.*

329. *Id.* Plaintiffs' preferences for jury trials may be legitimate, as evidenced by one state study which found that health care providers have won 92% of all panel decisions. See NAT'L L.J., Feb. 4, 1980, at 1, col. 4.

330. ABA REPORT, *supra* note 1, at 47.

331. INSTITUTE OF JUDICIAL ADMINISTRATION AND AMERICAN BAR ASSOCIATION, MEDICAL MALPRACTICE PANELS IN FOUR STATES (1977).

mandatory because voluntary panels are largely ignored.³³²

It is also significant that only the physicians on the panel may vote under the Nebraska plan. Although it has been argued that the "natural tendency of physicians will be to empathize with the defense,"³³³ this may be justified in light of the exceptionally complex issues involved in the typical malpractice case and the fact that these decisions are not binding. Moreover, the panel selection process is impartial, giving both parties a degree of input in selecting the panel members.

Another aspect of the Nebraska review panel which indicates that it will be successful is that the panel utilizes informal procedures throughout its proceedings.³³⁴ Theoretically this minimizes the expense and time necessary to appear before the panel. Many of the plans provide most of the procedural safeguards of a courtroom trial by allowing oral testimony and cross examination.³³⁵ Such full hearings may lead to more equitable findings and consequently encourage more settlements,³³⁶ but they are also more expensive³³⁷ and more time-consuming. Affording complete hearings

332. *Id.* at 42. Although the results were not conclusive, the study outlined the characteristics of those panels which disposed of the greatest number of cases. The study proposed:

1. The panel should determine both the extent of liability and damages.
2. The legislation must give teeth to the panel findings.
3. The chairperson of the panel must take an active role in disposing of these claims, and he must be able to control the panel hearings.
4. The panel members must be qualified in their respective fields.
5. The panels' performance must be evaluated.
6. The parties must be able to object to the panelists.
7. The evidence must be complete.
8. Procedures must be informal and open for discussion.
9. Panels must discuss their findings with the parties.
10. Panel hearings and findings should be confidential.
11. Complete data must be kept on the panel findings.
12. Panelists should be given immunity from civil suit for actions performed in connection with the panel.

Id. at 39-42.

333. Comment, *supra* note 25, at 1459.

334. NEB. REV. STAT. § 44-2842(3) (Reissue 1978).

335. See, e.g., ARK. STAT. ANN. § 34-2604 (Cum. Supp. 1979); FLA. STAT. ANN. § 768.44(6) (Cum. Supp. 1979).

336. Comment, *supra* note 25, at 1460.

337. At this stage however it may be too early to conclude that the review panel will significantly reduce costs. See Comment, ARIZ. ST. L.J., *supra* note 165, at 178-79; Comment, *supra* note 259, at 868-69. The panel may reduce costs only if the parties elect to settle at this stage. *Id.* If the parties are determined to have their day in court, this additional step of appearing before the panel would only increase the costs. This may present a serious impediment to the party with limited finances, see *Carter v. Sparkman*, 335 So. 2d 802, 807-08 (Fla. 1976) (concurring opinion), or a small claim. Plaintiffs with small claims

with all the procedural safeguards of a traditional trial would serve little purpose at this stage, particularly since the conclusions of the panel are not binding.

Although it may be too early to obtain any significant statistics concerning the effectiveness of these panels, comparison with other statutorily authorized systems is encouraging,³³⁸ because the Nebraska review panel incorporates many of the characteristics of the more successful panels from other states. Perhaps the most crucial element of the Nebraska Act is that panel findings are admissible in a subsequent trial. Allowing these findings to be admitted may dissuade the losing party from appealing.³³⁹ This is essential if the panel is to be effective since parties may simply go through the motions at this stage, in anticipation of presenting the full case to the jury at the trial stage. This practice would defeat the panels purpose, since very few cases would be settled at this preliminary stage. Nevertheless, many parties have attempted to frustrate the effectiveness of these medical review panels by merely presenting their claim to the panel without presenting any evidence, and the courts are split on how this action should be handled. For instance, in *Herrera v. Doctor's Hospital*,³⁴⁰ the plaintiffs filed their statutorily mandated request for medical mediation,

often do not pursue their cause of action because such claims are not economically appealing to attorneys and the malpractice procedures are confusing, time-consuming and expensive. See ABA REPORT, *supra* note 1, at 48-49. Furthermore, any additional delays at this stage will only increase the costs. However, these delays may be inevitable, particularly in cases involving multiple defendants. See MALPRACTICE REPORT, *supra* note 1, at 91; ABA REPORT, *supra* note 1, at 53-55 (40% of medical malpractice claims involve more than one defendant and it is not uncommon for a patient to sue three or more health care providers at one time).

It seems quite likely, then, that unless the review panels are capable of effectively encouraging settlement and screening malpractice claims from the courts, they very well may increase, rather than decrease, the cost of handling malpractice claims. But see MALPRACTICE DIG., Mar./Apr. 1978, at 3. A study of screening panels in Massachusetts indicates that they are screening out an extensive number of claims that should never have been initiated. Of 140 cases found to be insufficient to raise a question of liability, only 29 proceeded to lawsuit. This may be misleading, however, in that a party against who the panel renders an adverse finding must post a \$2,000 bond to proceed to trial. See note 306 *supra*. See also notes 347-48 & accompanying text *infra*.

338. See Baird, Munsterman & Stevens, *supra* note 267 (medical-legal screening panels reduce claims by approximately 24.5%, *id.* at 215; medical-legal panels estimated to cost approximately 40-60% of the cost of resolving a mid-range severity case at law, *id.* at 277; arbitration estimated to require 55-85% of the cost of a mid-range severity case at law, *id.*).
339. Some states not only admit the panel's finding but also presume that it is correct. The party rejecting the panel's decision must therefore sustain the burden of proving that the conclusion is incorrect. See, e.g., MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06(d) (Cum. Supp. 1979).
340. 360 So. 2d 1092 (Fla. Dist. Ct. App. 1978), *aff'd*, 367 So. 2d 204 (Fla. 1979).

but then refused to present any evidence to the panel. The trial court dismissed the complaint, reasoning that the plaintiffs' failure to offer any evidence to the panel amounted to non-performance of a condition precedent in a malpractice action and subverted the legislature's intent in creating the panel. However, this finding was reversed on appeal, where the court concluded that while the presentation of the claim was mandatory, the presentation of evidence was optional. Dismissal was deemed too harsh, since the party who neglects to present evidence suffers the consequences of having the panel's adverse finding admitted into evidence at the subsequent trial. This was a sufficient sanction according to the court.³⁴¹

A contrary result was reached in *Little v. Rosenthal*,³⁴² where the court found that the malpractice statute required the plaintiff to do more than simply plead facts constituting a cause of action to the panel. According to this court, the plaintiff did not satisfy his statutory burden of presenting evidence to the panel merely by making a verbal offer of proof.

Unless the panel's findings are admissible, there would be little incentive to settle.³⁴³ Merely admitting the panel's findings may not be sufficient to effectuate the legislative intent. Allowing petitioners to present their claim to the panel while presenting little or no evidence is a deliberate attempt to circumvent the Act.³⁴⁴ Con-

341. However, the plaintiff's attorney may be able to explain the adverse finding of the panel by simply stating to the jury that he presented no evidence to the panel because the plaintiff desired to have a jury of his peers, not a panel of physicians, evaluate the conduct of the health care provider. It is questionable whether the adverse conclusions of the panel would present any burden in this situation.

342. 382 N.E.2d 1037 (Mass. 1978).

343. Several commentators have argued that the prejudicial effect of admitting these adverse findings may be virtually impossible to overcome. See Comment, *supra* note 1, at 681. But see note 341 *supra*. There is fear that if the jurors give undue credence to these findings, the right to a meaningful trial will be diminished. See, e.g., *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 168, 355 N.E.2d 903, 908 (1976); Note, *supra* note 274, at 102. But in view of the rather limited findings which the panel may return, see text accompanying notes 301-05 *supra*, it seems that most juries would not be unnecessarily prejudiced by the panel's conclusion. See notes 316-18 & accompanying text *supra*. Compare this, however, with OHIO REV. CODE ANN. § 2711.21(C) (Page Supp. 1978), which allows the court to review the findings of the arbitration board before admitting them at trial. The findings are admitted only after the court concludes that: (1) The findings of fact by the arbitration board were not clearly erroneous; (2) The decision is in accordance with the applicable law; and (3) The procedures required for conducting the hearing and rendering the decision were followed fairly and properly without prejudice to either party.

344. *Herrera v. Doctor's Hosp.*, 360 So. 2d 1092, 1098 (Fla. Dist. Ct. App. 1978) (dissenting opinion), *aff'd*, 367 So. 2d 204 (Fla. 1979).

sequently, the legislation should be amended to mandate that all patients present both their claim and a reasonable amount of evidence which the party intends to present at trial. If on appeal the court determines that there has not been a good faith effort to comply with these provisions, the action may be dismissed. Since one purpose of the legislation is to assure the continuing availability of medical care through prompt and efficient claims disposition, it is not unreasonable to require good faith cooperation by the participants.

A final advantage of the Nebraska plan is that by enabling the parties to call the panel members as expert witnesses at trial, the plaintiffs are no longer at a distinct disadvantage due to the alleged "conspiracy of silence." This "conspiracy" exists when health care providers refuse to testify against their colleagues so that the patient is unable to gather any expert testimony.³⁴⁵ Allowing panel members to be called as expert witness increases the likelihood of settlement, since an adverse decision, particularly a unanimous one, would indicate that the plaintiff will have difficulty finding an expert witness to testify contrary to the panel's finding, thus limiting the plaintiff's chances of prevailing at trial.³⁴⁶ On the contrary, a favorable finding may exert sufficient pressure on the health care provider to reevaluate his position, since the patient would have at least two, and possibly three, qualified physicians to appear on his behalf.

345. It is virtually impossible (except perhaps in those rare instances where the health care provider's negligence is blatant) for a plaintiff to build a solid case of malpractice without expert medical testimony. But patients often complain that "doctors rarely, and then only reluctantly, testify against each other." MALPRACTICE REPORT, *supra* note 1, at 36. There is little hard, quantitative data to prove or disprove this theory, but several suggestions have been offered as to why health care providers might be reluctant to testify in malpractice cases: (1) Health care providers are reluctant to suffer loss of time and income which are often caused by a court appearance; (2) Health care providers are irritated by the time they must spend away from their patients; (3) Health care providers often resent and fear the probing cross-examination to which they are subjected. They are unprepared for frontal attacks on their creditability; (4) Health care providers experience difficulty and frustration in explaining complex medical principles to lay persons; (5) Health care providers are reluctant to injure friends and fellow health care providers. There seems to be a shared feeling among health care providers that "there but for the grace of God go I;" (6) Health care providers often feel that the majority of malpractice claims are without merit. 1 LOUISELL & WILLIAMS, *supra* note 78, ¶ 14.03, at 422-23. There is some indication, with the increasing acceptance of national standards and a more cooperative response from health care providers, that the "conspiracy of silence" may no longer represent a significant problem. See MALPRACTICE REPORT, *supra* note 1, at 36-37. This may also be due to the increased availability of medical review panel members to testify.

346. Comment, *supra* note 25, at 1462.

It may be too early to reach any definite conclusions as to the value and effectiveness of the Nebraska pre-trial review panel. However, with the exception of the noted deficiencies, Nebraska's review panel appears to be designed to be equitable yet inexpensive and efficient. Nevertheless, it is unclear what effect this panel will have on reducing the amount of malpractice litigation reaching the courts. Initial reports from other states indicate that the plaintiffs generally pursue their claims in spite of panel rulings favorable to the defendants.³⁴⁷ This in turn results in unwarranted delays and expenses for both the plaintiffs and defendants in the malpractice action.³⁴⁸ And although medical malpractice screening panels have survived initial constitutional challenges,³⁴⁹ this may represent only a temporary victory in what may be a prolonged battle. The Missouri Supreme Court³⁵⁰ recently decided that their screening panel was unconstitutional, and similar assaults are being staged in numerous other states.³⁵¹ The prognosis is not encouraging, but the experiences of other states should be cautiously compared to Nebraska, since this state's malpractice problem is not as serious as that in many other states. But in the final analysis the ultimate success of such panels may depend more on the degree of cooperation between the bar association and the medical profession than any combination of tort law modifications.³⁵²

347. NAT'L L.J., Feb. 4, 1980, at 1, col. 4. This article also concludes that screening panels in medical malpractice cases are "ill conceived, ineffective and invalid." *Id.* at 1.

348. *Id.* at 34. In Pennsylvania, for instance, panels have held hearings in only 14 of nearly 3,000 cases submitted to them since their creation in January 1976. *Id.* In Maryland, 315 of 350 claims submitted to the pretrial screening panel since July 1976 are still open, and most of those decided proceeded to trial regardless of the panels verdict. *Id.* The explanations for these delays include underadministration, poorly conceived plans and bureaucratic entanglements. *Id.*

349. See note 310 *supra*.

350. See *State ex rel. Cardinal Glennan Memorial Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979) in which a minor and her parents sued a hospital and six physicians for professional negligence. The plaintiffs failed to first submit their claim to the Professional Liability Review Board as required by MO. ANN. STAT. § 538.10-80 (Vernon Supp. 1980), and the defendants petitioned the court to dismiss the case for this reason. The court held that chapter 538, under which any person having a malpractice claim against a health care provider must refer the claim to the review panel before filing an action in court was unconstitutional since it imposed a procedure as a precondition to access to the courts.

351. See NAT'L L.J., *supra* note 347, at 1.

352. See Comment, *supra* note 161, at 1193 n.105.

IV. THE TRUE CRISIS: MALPRACTICE

The immediate malpractice crisis has temporarily abated, since adequate insurance is generally available for most health care providers and premiums for this insurance are significantly lower than during the crisis period. For instance, in Nebraska, the largest medical malpractice insurer was charging hospitals an average of \$737 per bed in July, 1976, but only \$185 per bed in July, 1979. In addition, the premiums for general practitioners dropped from \$737 a year to \$456 a year over the same period.³⁵³ But these improvements cannot necessarily be attributed to tort reforms which took place in the area of medical malpractice. The main reasons the crisis has eased are the development of joint underwriting associations, patients' compensation funds and doctor-owned insurance companies which have significantly increased the availability of malpractice insurance;³⁵⁴ the adverse publicity associated with large verdicts;³⁵⁵ an increase in the fees which health care providers charge their patients;³⁵⁶ and the switch by the insurance companies from occurrence to claims-made policies.³⁵⁷ The primary focus of legislative efforts has been to control the losses and costs associated with malpractice rather than to minimize the incidents of malpractice.³⁵⁸ Unfortunately, these measures have come at the patient's expense. And while these tort modifications may have had a minimal effect in easing the crisis, they quite simply do not reach the underlying problem—the occurrence of malpractice.³⁵⁹

Numerous studies indicate that there are many incidents of malpractice that do not result in malpractice claims. One recent

353. Lincoln Journal, July 22, 1979, § B, at 1, col. 1. *But see* NAIC STUDY, *supra* note 65, at 2 (from an analysis of 16,500 claims closed during a two year period (June 1976 to June 1978), "it would appear that malpractice claim costs continue to rise."). Evidence also seems to indicate that these rate reductions may be temporary, since "the number of medical malpractice claims in Nebraska increased substantially during 1978 and the first half of 1979 . . ." Omaha World Herald, Jan. 20, 1980, § B at 1, col. 1. Figures from St. Paul Fire and Marine Insurance Co., the major malpractice insurer in Nebraska indicate that in 1976, that company had 7.48 malpractice claims for every 100 of its insured physicians in Nebraska; this figure dropped to six percent per 100 doctors in 1977, but increased to 7.31 in 1978 and 12.2% for the first six months of 1979, *Id.*

354. *See* ABA REPORT, *supra* note 1, at 9-10. *See, e.g.,* NEB. REV. STAT. §§ 44-2837 to -2839 (Reissue 1978) (Residual Malpractice Authority was created to write medical malpractice liability insurance for those health care providers who are unable to obtain coverage).

355. ABA REPORT, *supra* note 1, at 10.

356. *Id.*

357. *See* note 89 *supra*.

358. *See* Comment, *supra* note 1, at 685-88.

359. ABA REPORT, *supra* note 1, at 10, 12. *See also* Comment, *supra* note 1, at 685-91.

study found that only one incident of malpractice out of every ten occurrences result in a malpractice claim,³⁶⁰ while a second study found that less than one-fifth of the incidents of malpractice result in claims.³⁶¹ In an extensive 1973 survey, two-fifths of the 1017 respondents participating in the survey stated that they, their spouses or their dependants had experienced adverse medical care within the past ten years.³⁶² Yet only thirty-seven respondents, or eight percent of the respondents reporting adverse experiences, indicated that legal advice was considered.³⁶³ And one HEW official estimates that as many as 700,000 medical injuries annually may be the result of health care malpractice.³⁶⁴

These studies provide some indication that the eventual solution to the medical malpractice problem lies not in altering the malpractice litigation system, but in reducing incidents of malpractice. Long term solutions will result only when malpractice is recognized as the essence of the problem. Unfortunately, the Nebraska Act treats malpractice litigation, not malpractice, as the source of the problem.

V. LEGISLATIVE RESPONSES TO THE TRUE CRISIS

The Nebraska legislature has taken several steps designed to improve the quality of health care which should ultimately have a beneficial effect on the malpractice problem. First, the Commission on Medical Qualifications was created to monitor the conduct

360. MALPRACTICE DIG., Jan./Feb. 1979, at 4.

361. MALPRACTICE LIFELINE, June 30, 1978, at 1.

362. Peterson, *supra* note 44, at 668-75. These perceptions, however, do not establish that there was malpractice.

363. *Id.* at 674-75.

364. STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 1ST SESS., AN OVERVIEW OF MEDICAL MALPRACTICE 13 (Comm. Print 1975). In addition to malpractice, many injuries result from unnecessary operations:

[S]ome studies indicate that there are from two to three million unnecessary operations performed each year, wholly apart from professional malpractice, which costs Americans between three and four billion dollars. . . . These unnecessary operations also cause medical injuries and deaths. The deaths caused by these unnecessary operations have been estimated at between 11,000 and 16,000 annually. . . . [I]t seems fair to conclude that over a million medical injuries and many thousands of deaths caused by these injuries annually are the product of either medical malpractice or unnecessary operations performed by physicians and other health care providers.

Witherspoon, *supra* note 3, at 442 n.115.1. See generally I. IVAN, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH (1976); H. LEWIS & M. LEWIS, THE MEDICAL OFFENDERS (1970). See also, *Getting Ready for National Health Insurance: Unnecessary Surgery, Hearings before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce*, 94th Cong., 1st Sess. 59-73 (1975) (testimony of Sidney Wolfe).

of health care providers.³⁶⁵ This commission hears complaints on the activities or qualifications of any physician or surgeon licensed to practice in Nebraska.³⁶⁶ Commission members enjoy broad investigating powers³⁶⁷ and civil immunity from "liability of any kind based upon any act or omission while acting in the course of [their] duties . . . as such commission members . . ."³⁶⁸ so that they may freely investigate charges against medical personnel. If the commission determines that the complaint has merit it must submit the evidence to the Director of Health for a formal hearing. The physician or surgeon may have his license revoked or he may be subjected to other penalties for a variety of reasons.³⁶⁹

This commission should certainly have a beneficial effect on the delivery of health care,³⁷⁰ and more importantly, it will serve as a forum for patients to channel their grievances without initiating causes of action in court. If the patient feels that he is not being ignored, that someone is listening to and acting on his complaint, this may ease many of the feelings of frustration and alienation, feelings which often result in a suit.³⁷¹

Perhaps more importantly, the detailed data³⁷² collected for

365. See NEB. REV. STAT. § 44-2848 (Reissue 1978). This commission consists of two medical doctors (engaged in active practice in Nebraska and who have practiced for at least 10 years) to be appointed by the Board of Examiners in Medicine and Surgery; two members of the Nebraska Medical Association who are designated by the Association; and one physician appointed by the governor. *Id.* § 44-2848(2).

366. *Id.* § 44-2851(2).

367. *Id.* § 44-2851(4).

368. *Id.* § 44-2853(4).

369. *Id.* § 44-2853(1)-(7). These reasons include:

- (1) Willful disregard of or failure to perform his duties and obligations to a patient;
- (2) Habitual intemperance;
- (3) Conviction of a crime involving moral turpitude;
- (4) Gross negligent acts in performing his duties as a physician;
- (5) A continued course of negligent conduct . . . ;
- (6) Physical or mental disability materially affecting his ability to perform his duties in a competent manner

Id.

370. But see Comment, *supra* note 1, at 686-87, in which the commentator concludes that measures such as Nebraska's Commission on Medical Qualifications

cannot be expected to contribute significantly to a reduction of malpractice. Rather than arising from incompetence, malpractice is more often produced when a competent doctor makes a mistake or a normally reliable procedure breaks down. Because medical incompetence is but an infrequent cause of malpractice, controlling it will have only a limited influence on the number of claims that result.

(footnote omitted).

371. See MALPRACTICE REPORT, *supra* note 1, at 84. See also notes 77-87 & accompanying text *supra*.

372. See NEB. REV. STAT. § 44-2835 (Reissue 1978).

this commission will prove invaluable in pinpointing the procedures and situations that result in malpractice.³⁷³ Whenever a malpractice claim is settled or finally decided, the plaintiff's attorney and the health care provider must report the following information to the director of insurance: the nature of the claim; the alleged injury and the damages asserted; the attorney's fees and expenses incurred in connection with the claim or defense and the amount of settlement or judgment. This report is then forwarded to the Medical Qualifications Committee for their consideration and action.³⁷⁴ But to be fully effective this knowledge as to how, when and where claims arise must be fully utilized after it is gathered.³⁷⁵ In order to develop an effective medical injury prevention program,³⁷⁶ this data on the frequency and causes of adverse medical incidents must be carefully analyzed, and appropriate measures must be designed to minimize potential future occurrences. Procedures and circumstances giving rise to frequent malpractice claims should be "isolated and analyzed to determine what therapeutic action should be undertaken to prevent malpractice and the injuries it causes."³⁷⁷

A second legislative provision (not included in the Nebraska Malpractice Act) which should have a minimal effect in reducing the incidents of malpractice is the hospital review committee.³⁷⁸ This committee periodically reviews the quality of medical care provided in the hospital in order to insure that the hospital staff exercises a high standard of care and to promote the most efficient use of the hospital facilities.³⁷⁹

Unfortunately, the hospital review committee may not be able to analyze effectively and remedy malpractice in the hospital, since there is neither a systematic approach to analyzing the occurrences of malpractice nor any suggestion as to how such incidents may be resolved once they are discovered. Since the majority of malpractice incidents occur in hospitals,³⁸⁰ it is imperative that the legislature and the health care industry focus their attention on developing a comprehensive medical injury prevention program. The hospital is certainly the best environment to monitor injuries and initiate effective efforts to reduce adverse incidents. It is also essential that these programs be comprehensive:

373. See generally MALPRACTICE REPORT, *supra* note 1, at 45, 84; ABA REPORT, *supra* note 1, at 99-103.

374. NEB. REV. STAT. § 44-2835 (Reissue 1978).

375. Comment, *supra* note 1, at 687-88.

376. MALPRACTICE REPORT, *supra* note 1, at 61.

377. Comment, *supra* note 1, at 688.

378. NEB. REV. STAT. §§ 71-2046 to -2048 (Reissue 1976).

379. *Id.* § 71-2046.

380. See MALPRACTICE REPORT, *supra* note 1, at 61.

Injury prevention programs should focus on *every potential source of injury* to patients, including medication errors, slips and falls, faulty medical equipment, inadequate supervision of personnel, break-downs in communication, unnecessary surgery, inadequate record-keeping, and other sources of potential harm—whether or not related to negligent conduct. As new and more sophisticated methods for preventing injuries are developed, they should be expanded to include medical injury prevention in physicians' offices and other non-institutional settings.³⁸¹

Florida, for example, has created an internal risk management program in every hospital or facility providing in-house patient care.³⁸² This comprehensive program is designed to investigate and analyze specific and general categories of adverse incidents causing injuries to patients; to minimize the risk of further adverse results; to analyze patient grievances relating to patient care and the quality of medical services; and to develop an extensive incident reporting system. In addition, the legislation provides that any "innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated."³⁸³ Potential problems can be avoided and effective programs developed based on individual experience in the patient care facilities or institutions. This plan offers several distinct advantages.

First, the program attacks the malpractice problem at the outset with preventive measures such as the patient grievance mechanism.³⁸⁴ If effectively administered, this device can respond to patient grievances before they become claims. Second, in addition to focussing on adverse injuries which can be attributed to medical negligence, this plan attacks those procedures causing adverse results which may not be attributable to medical negligence.³⁸⁵ This will assist in improving those areas which potentially may result in malpractice claims, although the injury itself is not caused by malpractice. Finally, this plan encourages the cooperation of all health care personnel and patients in eliminating potential trouble areas, so the quality of health care should improve while the number of malpractice claims is reduced.

VI. CONCLUSION

The Nebraska Hospital-Medical Liability Act may have been an expedient solution to the malpractice crisis in the mid 1970's, but it

381. *Id.* (emphasis added).

382. FLA. STAT. ANN. § 768.41 (Cum. Supp. 1979).

383. *Id.* § 768.41(3).

384. For a discussion of patient grievance mechanisms, see MALPRACTICE REPORT, *supra* note 1, at 83-87.

385. Principles and guidelines which are important in the success of hospital patient safety programs are found in ABA REPORT, *supra* note 1, at 118-26.

should not be considered the ultimate solution.³⁸⁶ The legislation significantly alters the malpractice litigation system at the patient's expense, but it provides very little in the way of long term answers to the problem of medical malpractice. In contrast to these sweeping reforms aimed at guaranteeing the availability of malpractice insurance, very little has been done to minimize the occurrence of malpractice.

Several provisions of the Act are troublesome, particularly those which limit the recovery for the seriously injured patients, impose a statute of limitations, and allow the court to review an attorney's fees. Ultimately, however, truly remedial legislation should focus on designing comprehensive programs to improve relations between health care providers and patients; to minimize the occurrence of any incidents, whether or not attributed to malpractice, which may give rise to malpractice claims; and to encourage cooperation between health care providers, the legal community and patients. The malpractice dike is plugged temporarily, but it seems unlikely that it will hold unless we begin addressing the source of the problem—the occurrence of malpractice.

David J. Dempsey '80

386. One recent insurance study of malpractice tort reform legislation in California indicates that this legislation may have increased claims, awards and settlements in that state. The downward trend in the amount of settlements and verdicts in 1975 and 1976 (subsequent to passage of sweeping tort reform legislation in 1975) "dramatically reversed" in 1977 and 1978. *MALPRACTICE LIFE-LINE*, May 25, 1979, at 4. See also Comment, *supra* note 1, at 688-89 (malpractice legislation is "shortsighted and designed to have only a palliative effect upon the very serious problem of medical malpractice. . . . [T]he potential for a future crisis, still exists, relatively unscratched by the recent flood of legislation.").